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Nova Scotia Reviews

WEBSTER defines retrospection as "A review or contemplation of past events." It is an activity one should indulge in more often, not because it will be an enjoyable pastime — on the contrary, it can be a very depressing experience — but because it will help to judge the past more objectively so that plans for the future may be properly evaluated.

As we, in Nova Scotia, review the events of the past few years, we acknowledge several disappointments. Our hope for an advisory-registrar, and our hope that a post-graduate school for nurses would be opened in Halifax in 1947 remain just that, hopes, for the present. We realize that the time was not ripe for either, and so, with our zeal in no way lessened, we await the opportune time.

In nursing education we are keenly aware of the "trends." We are quite conscious of the fact that many outside of our profession, and some within its ranks, are not quite satisfied with what has been accomplished in nursing education to meet the health needs of the general public. We believe that as a provincial association, we have some responsibility in the matter, but just where to begin is the question. We are convinced that we shall be benefitting the professional nurses of the future if the educational standards,

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both for entrance into Nova Scotia schools of nursing and for registration, are raised. With that thought in mind, the Legislation Committee has been very active although there is no new legislation to show this. We are at the same time conscious of the inequality of standards concerning the admission requirements to enter schools of nursing and, similarly, to become registered in the other provinces of the Dominion. It would seem an excellent idea to have all students meet university entrance requirements, but these vary and one wonders, while trying to revise the Constitution and By-Laws as we are, just what to specify as requirements, so that students will not be handicapped in their choice of a school for post-graduate work. Would Dominion examinations be the answer to the second part of the problem? This question has received some study and will receive a great deal more before we arrive at a final decision concerning the proposed revision of our Act.

For some time, the advisability of introducing qualifying examinations at the end of the first year has been under consideration. However, it does not seem practical to adopt the policy until the Act is revised.

Every attempt is being made to secure more satisfactory clinical affiliations for our students. The clinical material is here and the administrators of the hospitals and departments concerned are ready to cooperate, but here, as elsewhere, there has been a dearth of qualified teaching and supervisory personnel and, up to the present, such expansion would not have been educationally sound.

In spite of the fact that more nurses have been graduated during the past years, the number available to maintain a desirable nursing service and to give adequate nursing care is still below our needs. Hospital staffs are not stabilized although there is some improvement. Most hospitals would use more general duty nurses and more qualified personnel for head nurse and supervisory positions, if more nurses would become interested in what someone has termed "the adventure of bedside nursing." Perhaps there is criticism of the hours of duty, working conditions, etc., in Nova Scotia as elsewhere, but every attempt is being made to improve these and at the same time to convince those interested in institutional nursing that reasonable demands will be met as soon as the staffs are large enough to ensure to the patient the best of nursing care. In view of the expansion of hospital facilities now nearing completion, with their improved teaching departments, and those planned for the near future, Nova Scotia anticipates an even greater demand for general duty nurses and a larger student enrolment.

Here as in the other provinces emphasis is being placed on preventive medicine and all public health departments have increased their personnel. More and more of the industries are employing nurses, some of these being qualified public health nurses. Several Red Cross outpost hospitals have been opened this year to provide nursing care in the more isolated areas of the province where no other hospitals or nursing service are available. These are in the charge of registered nurses who are to be commended for their work in these outlying districts.

The "nursing attendant," as she is designated by members of the R.N.A.N.S., has come in for a considerable share of attention. It is hoped to include these workers under the provision of a Nurse Practice Act; the Legislation Committee is working out the details. In the meantime some of the local registries have decided to enrol any nursing attendant who wishes to take advantage of their facilities, provided she meets certain requirements.

Although there seems to be little tangible evidence of the work that has been done, the fact remains that a real interest is being shown and there is every reason to be optimistic about the future of nursing in Nova Scotia.

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Health Problems of an Aging Population

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IT IS IN the interests of the health and general welfare of our people that we consider at this time the trends of our population and the associated problems with which we, as a nation, are faced. From a study of statistics, which can at times be horribly dull, certain very specific facts may be elicited—facts which are indisputable, facts which can convey a very enlightened message, facts which will permit us to plan accurately and wisely, facts which will shock some, amuse others, leave unmoved those who are insensible to their community obligations, and stir up an added sense of responsibility in those who already have a keen interest in the welfare of their fellowmen.

A few figures must be used in establishing certain facts. Please do not make an effort to remember them, they are only confusing; but simply remember the general trends as indicated by any statistical comparison which I may make.

There are several important factors which influence the age composition of the people, the two main ones being the proportion of births and deaths and the population growth. In 1921, the birth rate in the Province of Ontario was approximately 24 per 1,000, and by 1939 it had fallen to 17 per 1,000. Not only is this decrease to be observed in Ontario but it is significant throughout all the provinces, including the Province of Quebec. The decrease in birth rate in Ontario and Quebec is almost parallel, although the actual birth rate is higher in Quebec than it is in Ontario. This decrease obviously means fewer children and, correspondingly, more adults in our communities. This is the first step in developing old age problems.

One must not forget that though the birth rate is decreasing, there is a vast improvement in infant mortality. In 1921, approximately 83 infants died for every 1,000 live births, whereas in 1942 only 40 infants died for every 1,000 live births. Better medical care, pre- and post-natal examination, control of infectious diseases, higher standards of living, and better education in health matters, all have been important contributing factors in more than halving infant mortality in those twenty years. Simultaneously, these same factors have been responsible for slashing maternal mortality from 58 childbirth deaths per 10,000 live births in 1926, to 23 per 10,000 live births in 1942. But let us remember this wonderful saving of mothers at childbirth adds to our adult population now as it did not do twenty-five or fifty or a hundred years ago.

We have, all of us, more or less glibly talked about people living longer now than they used to live. Here are a few facts: read them and then forget them! In 1741, the expected length of life in civilized European countries, including the British Isles, was 30 years! No wonder they had to pack a lot of fun into a few years in those "good old days." By 1841, the life expectancy had risen to 40, by 1891 to 44, by 1921 to 55 and, in 1941, to 63 for males and 65 for females. Control of diphtheria, typhoid, smallpox, tuberculosis, enteritis, and other communicable diseases; better medical care, including better diagnosis; better education; better working conditions, including the abolition of child labor; better nutrition, hygiene, and sanitation, have been responsible for this increased life expectancy. Through such control, too, there has been produced a modification of our population which influences not only the whole picture of health and disease but the whole structure of society.

With all of these factors working to increase the life expectancy of our peoples and with the decreasing birth

rate, it is obvious that, as each year passes, more and more of our population must pass into the older adult age group and, in fact, that is exactly what is happening. In 1897, fifty years ago, 8.5 per cent of the population was over the age of 60. By 1921, 9.2 per cent was over 60; by 1941, 12 per cent was over 60; and by 1961, almost 14 per cent of our population will be 60 years of age or older. These are significant figures and should make us pause and consider if our planning has taken cognizance of these facts. Nothing can decrease the ultimate death rate; factors mentioned simply delay the inevitable, but in doing so our population gets older.

As our population gets older many new economic, social, cultural, and medical problems arise which are not being faced with the degree of energy which they warrant and ultimately must receive.

With fewer children in our families, more outside facilities for pleasure and the progressively increased cost of living, large homes are becoming obsolete. Small homes and apartments are the rule in urban centres, with large homes the exception even in rural areas. It becomes, therefore, increasingly difficult in small homes or apartments to provide space, facilities, or the care necessary to look after the sick, the convalescent, or the aged in poor health.

The great and increasing demand for social security legislation indicates not only a desire for protection but a fear of not being able to support oneself in older age. The noted success of sickness and hospitalization plans, whether sponsored by government, insurance companies, or by any other agency, indicates a realization on the part of the public that health protection is important and can be paid for on the prepaid low-cost instalment plan. It indicates, too, a fear of the "calamity" illness which can, so quickly, completely wipe out a family's savings and even put them in debt for years. It indicates also, as previously intimated, an acceptance of the idea that the small home or apartment is no place in which to care for a really sick person, the maternity case, or the dying cancer patient, particularly if young children are in the household. What can be worse than for young children and a parent, in a four-room house, week after week, watching and caring for the complete and helpless deterioration of the other parent suffering and dying from cancer or paralysis following a cerebral accident?

In this new country of ours, with the advantages of tremendous resources and skills, many new industries, requiring new techniques, are springing into existence. These new industries, in general, require young people in their employment. Those older industries which are declining in importance and being pushed aside by the new industries will be found to be employing older people—people who have been in their employment for many years. As these older industries and trades decline a new problem arises, that of the increased numbers of workers in the older age group relative to the numbers of younger workers. It has been estimated that by 1975, which is less than thirty years from now, an increase of only 6 per cent in the number of workers between 20 and 44 years of age can be expected, while an increase of 69 per cent can be expected of workers between 45 and 64 years of age. Therefore, the aging of our population creates conditions affecting the employment of older workers. The problem of retaining these people in employment and increasing their adaptability to new techniques and machines must be solved. There are other economic difficulties created by an aging population, but the few which I have touched upon will give you some idea, at least, of the magnitude of the problem.

Besides the economic considerations, one must recognize, too, the cultural problems. It has been stated most adequately that "the vigor and happiness in old rests upon the foundation of good health and intellectual vitality in youth." The whole problem of education and training of

the youth, and continuing or adult education, with all the implications of the development of the mind and the body, associated in the end with character, wisdom, knowledge, and judgment, is implied in the above quotation. True pleasure and happiness should not be denied our people; a good philosophy can be developed by everyone, a warped philosophy only by an unhappy individual.

There is one further problem which I would like to discuss as it is part of the picture of an aging population. We have in Canada approximately 124,000 hospital beds of which about 52,500 are general hospital beds, provided essentially for acute general hospital cases. One frequently hears complaints about the shortage of hospital beds and the long waiting-lists of patients for admission. You should, therefore, be interested in just a few more figures, and then, as before, forget them. Taking the result of a 1936 U.S. survey of the "number of days of disability per person observed per year," (how complicated that sounds!), and dividing cases into acute and chronic, we find that, for those in the age group of 25 to 65, there is an average of 2.2 days of disability per year in the "acute" class and 8.4 in the "chronic" class. For those in the age group of 65 and over, we find 2.7 in the "acute" class, not very much greater than in the younger group, but in the "chronic" class we find 33. Compare, then, 8.4 with 33 and you have the significant fact.

Closer home, a survey conducted by members of the University of Western Ontario staff this year revealed that in all western Ontario general hospitals, 33.8 per cent of all patients, male and female, were over the age of sixty. The diagnoses, with respect to the patients over sixty, were as follows:

	Per cent
Cardiovascular — renal	17.8
Accidents, including fractures	15.1
Cancer	13.7
Pneumonia and influenza	13.7
Prostate and bladder	9.6
Hernia and obstruction	8.2
Diabetes	6.8
Arthritis	4.1
Gall bladder	2.7
All others	8.3

The amount of chronic disease in those over sixty is seven times greater than in those under sixty. It may be of interest to you, and I think it should be, to know that, in Ontario alone, the number of patients in mental hospitals has increased from 10,488 in 1931, to 15,073 in 1945, a ratio of 376 per 100,000 of population and still the mental hospitals are crowded. Mental illness is not mental deficiency. The vast problem of mental disease is perhaps the most baffling in the entire field of health. Mention of mental health would have no place in this article if it were not for the fact that of all first admissions to these mental hospitals in 1945, 29 per cent were over the age of sixty. So once again, we have a demonstration of the effects of the aging problem since most of these patients were admitted on the basis of mental illness resulting from arteriosclerotic changes, and from family situations—the end result of the social problem of the "unwanted" old folks. There is a vital need for extensive and uniform mental health surveys in our country.

In our survey, with approximately four thousand general hospital beds in western Ontario providing 1,460,000 hospital day beds, 511,000 were occupied by those patients over sixty. I am not for a moment saying, or even thinking, that we should not provide hospital beds for ill people over sixty years of age, but I do think, and I state emphatically, that chronic cases are using up an inordinately high percentage of the beds in our general hospitals which were built and equipped, at high cost, for the care of acute general hospital cases. Operating-rooms and equipment, x-ray and radium therapy equipment, emergency quarters, plaster rooms, anesthetic equipment, diet kitchens, laboratories, and all of those other services which are required for a general hospital, and the highly qualified staffs which must be available, make a general hospital an expensive

concern to operate. Most of these facilities are not required in a hospital for chronic or convalescent patients, particularly if such hospitals are operated near a general hospital where operative, x-ray, and other facilities are available. The costs of a convalescent hospital are, therefore, about one-third of those for a general hospital.

If we take cognizance of facts, our communities would be building not more and bigger general hospitals at approximately $10,000 per bed, but more and more hospitals for convalescent and chronic patients at about $3,000 per bed. Such hospitals could be built to advantage, not in the centre of a smoke-filled, noisy city or town, but somewhere nearby where green fields, a stream, a river or a lake, trees and flowers, and fresh air and sunshine would combine with good medical care to promote recovery, restore health, and provide some degree of happiness.

Our population is getting older. The conservation of all of Canada's resources, human as well as natural, is a matter of prime importance.

Chronic Illness

SARAH B. GELBACH, R.N., B.S.

AGING IS A PART of living and the nurse has much to do in educating the family to a kindly recognition of this group. Chronic illness is an important factor as a cause of dependency. Economic loss as well as a feeling of uselessness causes more heartache than the chronic diseases themselves.

From 1910 to 1940 the number of persons over forty-five years of age increased from 17 per cent of the total population to 26.5 per cent. The present estimates are that, by 1970, more than half of the population will be over forty-five years of age, and that each working hundred of the population will have to carry forty-five persons over sixty-five years of age, if these people have not saved enough money to care for themselves. This increase in the span of life increases the number of persons subject to chronic diseases, a problem so important from a medical standpoint as to have given rise to a new specialty—geriatrics.

It is the desire and aim of hospital administrators to provide the sufferers from chronic medical, surgical, and neurological ailments with improved and scientific care, and to conduct investigation if the field of chronic diseases. Unfortunately, it is the exceptional nurse who is interested in and challenged by the chronic patient. An accurate picture of the trends in nursing is shown when recently graduated nurses reveal they have not had the thrill of nursing a patient through a pneumonia crisis, due to developments in chemotherapy. Real nursing is not expressed through the practice of artistic procedures and relationship but has always been made known through love, sympathy, knowledge, culture, and ideals. The better nurse is that one who has a real feeling for philosophy. A nurse-in-training must not get the viewpoint of simply administering to her patients without knowing why she does the various treatments. There must be a desire to learn. The nurse in the field of chronic diseases, which is a much bigger field than acute nursing, must have humor, patience, ability, and quantities of imagination.

Most people are reasonably patient with the lame, the blind, and the halt. We will have to teach them to be patient with those who are sick with a long-term disease also. Chronic illness is increasing and is with us to stay. The care of the chronically ill

is a responsibility of the public.

The confusion of chronic disease and senescence leads to neglect and maltreatment of the chronic sick just as does the concept of incurability. True aging and gradual senile decay may become noticeable after seventy years of age. Persons between their fiftieth and seventieth year, who are disabled and infirm, should be regarded as sick, not as suffering from the decrepitude of old age. In old people, there is a gradual wearing out, an enfeeblement of their organs and tissues which are experiencing a slow progressive decline. Within these limits, they may have no serious organic defect, but are no longer strong enough to carry on unaided.

However, 15 per cent of chronic disease occurs below the 16-year age group when we find such conditions as rheumatic fever, which affects 10 per cent of the population, rheumatoid arthritis, osteomyelitis, poliomyelitis, and tuberculosis, particularly the bovine type, pulmonary tuberculosis, diabetes mellitus, and chronic blood diseases such as syphilis, pernicious anemia, etc.

If we agree that existing facilities for the care of the chronically ill are inadequate, a practical program must look forward to determine the future needs. Institutions with a sound program have given careful and serious consideration to the following fundamentals:

1. Relative distribution of responsibility between voluntary, philanthropic, and official authorities.
2. Responsibility of the government for the care of the indigent.
3. Desirable size and location of institutions.
4. The extent to which beds are needed in hospitals and treatment centres as distinct from homes for patients who cannot profit from treatment but need continual personal and nursing care.
5. The most satisfactory methods of financing care for patients unable to pay in whole or in part.
6. The most effective means of maintaining adequate standards of care—i.e., through licensing laws, periodic inspection by provincial and local authorities.

Prevention of the chronic diseases is the first concern. It should begin with adequate education in personal hygiene, right living, and suitable diet. It includes an annual health examination which may reveal a focus of infection which can be removed before the secondary effect results in disability.

The medical profession has realized the need for institutions for those of the chronically ill, convalescent, and incurable who cannot be cared for at home. It is not a matter of debate whether such facilities should be provided as separate institutions or as wings on an acute disease hospital. It is essential that these be unattached units. The way to successful treatment lies in the examining and screening of patients in a special diagnostic clinic and segregating them for care in the chronic disease units or homes for the aged.

Staff must be adequately prepared to meet the needs of this field. Nursing the chronically ill requires a sensible balance between the requirements of the brain and the requirements of the heart. There is a place here for the nurse aides but the work should be planned and organized by a fully qualified nurse. Only in that way can the best care for the chronic patients be guaranteed.

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The Care of the Chronically Ill

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DURING THE past twenty years it has become increasingly apparent that the sociological changes due to increased length of life and the change in population from rural to urban was rapidly reaching a point where action was necessary in order to care adequately for the chronically ill. That this point has now been reached is evidenced by the prominence given it in the press and, more concretely, by the building and expansion programs being undertaken.

The classification of the chronically ill made by Mr. Donald M. Cox, secretary and manager of the Winnipeg Municipal Hospitals, in the April, 1946, issue of *The Canadian Hospital*, helps to clarify our thinking in this connection:

1. Those requiring intensive medical and nursing care for both diagnosis and treatment.
2. Those requiring skilled nursing and medical care but relatively little in the way of specialized treatments.
3. Those who suffer from permanent disabilities and who require considerable assistance and supervision but relatively little medical and nursing care.

When the chronically ill are divided into these three classifications several questions come at once to one's mind. Should they be part of or closely associated with a general hospital in order to give, most advantageously, intensive medical and nursing care for treatment and diagnosis? Should they be in a hospital in the country where there is fresh air and sunshine? For the custodial group, should they be in hospital at all or is there not a more suitable setting for many of them where an educational program could be carried on directed toward personal and financial independence?

There will be differences of opinion as to how the chronically ill can best be cared for but few will dispute the fact that they deserve the very best type of care.

Hospitals for continued care should be bright and cheerful. Color therapy should be employed to take away from the monotony of dull walls. Colors have a definite effect upon the mental and physical state of everyone. Colors correctly used cheer our spirits and increase our sense of well-being; incorrectly used colors depress us. If tones and tints affect those who are well, how much more do they affect those who are forced to stay in one room for long periods of time?

There are many small details which help to make a hospital of this type satisfactory. Floors which are warm, not too highly polished, and easily cleaned are helpful. Small wards of not more than four beds and many single rooms add to the comfort of all. Gay hangings are much appreciated, as are low windows where the street or garden may be seen. Good pictures in the day-rooms and corridors add interest for both patients and staff. Balconies, solariums, and a garden are thoroughly enjoyed. Bathrooms should be easily accessible, with the basins placed low enough so that patients in wheel-chairs may be able to care for themselves. Handrails placed in strategic positions and low bathtubs placed well out from the wall are a few of the details which help facilitate care.

In the care of the chronically ill many supportive services are necessary. Dental and oculist services are essential and physiotherapy and occupational therapy form an invaluable part of patient care. These necessitate treatment rooms, workrooms, and an auditorium.

The nursing care of the chronically ill has been described as the acid test of nursing skill. Certainly their nursing care requires all the resources of a well-integrated personality as well as those of a skilful nurse, for here we are apt to find patients who are discouraged over a long illness, fearful, introverted, and demanding.

Intensive Medical Care for both Diagnosis and Treatment

There is little difference in the nursing care required by the first two groups. In both, we might expect to find patients with cardiac disease, anemia, arthritis, carcinoma, or diabetes. Such patients require the same skilled nursing care as those who are acutely ill and, in addition, vigilance in detecting and reporting symptoms which might easily be overlooked in a person who is chronically ill, symptoms thought to be "the same old complaint."

When possible, getting patients out of bed daily seems particularly important. It helps to keep their joints flexible; it tires them so that they sleep better at night; they are able to do more for themselves; it stimulates them mentally; they seem less susceptible to respiratory infections.

Those who have to spend long months or years in bed require extremely good care of the skin with special attention to pressure points. Diapers can be most useful for incontinent patients who are turned, washed, and changed every three or four hours. Nurses should be encouraged not to put pads inside diapers as these hold the urine and are apt to irritate the tissues.

The prevention of bed sores is an unending struggle. Reddened areas must be massaged thoroughly, washed with soap and water, and well dried. Frequent changing and proper turning of patients is the greatest aid in avoiding bed sores. When an area is broken down the treatment varies, depending on the site and severity of the abrasion. Considerable success with deep ulcers has been achieved by the use of sulpha or penicillin.

The diet of the chronically ill is a very important part of treatment. Surely no other type of patient is more deserving of good food than these long-term patients who may develop serious nutritional deficiencies if their diet is inadequate. Who could possibly appreciate more thoroughly receiving attractive, hot, well-cooked meals, when the appetite is apt to be jaded and interests, of necessity, have become fewer and fewer? As much as possible, patients should be encouraged to take time to feed themselves. For those patients who have difficulty or who cannot feed themselves the nurses must give the necessary assistance. A good bed-tray of some type is most helpful, and a dining-room is of very great value for up-patients. A soft, bland diet is necessary for some but for the majority a diet which resembles as closely as possible that which one might find in a home is provided. Patients, particularly, enjoy such things as pie, pan-cakes, salads and relishes. The gastric upsets one might expect from the inclusion of such foods in the diet seem to be counteracted by its enjoyment.

In a hospital for the chronically ill there are many aged people and this is a whole subject in itself. Characteristically they are forgetful, tend to reminisce and to fabricate. Therefore, the nurse caring for these people should be kind, understanding, and willing to take time to listen sympathetically to their stories. Many are untidy and disinterested in their appearance so it becomes necessary to encourage a pride in personal appearance. They are often lonely and need to be encouraged to keep in touch with friends by visits or correspondence. Former interests and hobbies should be encouraged and the development of new ones fostered. Rules and regulations should be kept at a minimum, for these are persons of many years of habit who are apt to resist coercion imposed by younger people. Recreation suited to their limited powers of concentration is desirable. Perpetual idleness leads them to resort unconsciously to neurotic devices exploiting a genuine illness or inventing one for sympathy.

Permanent Disabilities Needing Supervision and Assistance

Among the disabled we find two groups in the hospital for the chronically ill: Those who have been handicapped for many years and who have more or less become adjusted to their condition; those who have been trans-

ferred from a general hospital and are now facing the prospect of continuous hospitalization. In either group there are aged and young. The older ones have various diseases of the nervous system, paralysis due to other causes, cardiac conditions, or arthritis. The younger ones are usually hospitalized because of cerebral palsy, traumatic paralysis, or poliomyelitis.

It is heart-breaking to watch such patients slowly lose courage and hope, wondering why they have to live. They must be provided with something to make the day worth living through. They must be helped to create a place for themselves in the scheme of things. There must be a willingness to struggle patiently with nature in order to win even a partial cure. The term "incurable" must never be mentioned. What was once considered incurable may now be cured. Think of the difference in the prospect for paraplegics after World War I and World War II. There is need for a change of perspective on the part of the community, the family, and the medical and nursing professions in regard to chronic disease.

It is impossible to avoid entirely an atmosphere of institutionalism but much can be done to make a hospital friendly in spite of its size. A sheltered workshop would seem ideal for the physically handicapped where they would be away from those acutely ill, and from the senile and arteriosclerotic patients who so far do not seem to belong anywhere. Here they might be trained to become happy, self-supporting citizens.

The permanently disabled have time and energy to study and appreciate hospital facilities. Some of the details which they most appreciate are: Privacy for treatment through the use of cubicle curtains; the security of having a call-light; sufficient storage space in roomy bedside tables; bannisters and hand-rails where necessary; adequate lighting for reading; good meals served attractively with reasonable catering to individual tastes; liberal visiting hours; opportunity for religious observances; a united cheerful staff; attention to dental needs, care of the eyes; library service; an occupational therapy department, in fact anything which emphasizes capabilities rather than disabilities. This attention to the psychological reactions of the patient is most important, for flabbiness of the spirit can be as serious as flabbiness of the body. A handicapped person should be treated as a normal human being. He must not be babied, nor must he be urged to do things which are physically impossible for him, but everything he can do should be required of him. The handicapped should be expected to observe the conventions and emotional restraints expected of normal people. To make allowance for rude or childish behavior simply on the basis of the handicap is a great mistake. When temper tantrums do occur the removal of the person to a single room where there is no audience seems to be most effective.

These patients, as do all patients, need someone to talk with, to discuss their interests and their problems. In a hospital providing continued care, the nurse has the advantage over the nurse in a general hospital who, particularly in these days, has little time to talk to anyone. The former gets a second chance to do many things she has always wanted to do for which she never had time. There is some excuse for strict attention to business in general hospitals, but in hospitals for the chronically ill the content of the "business" changes. Here emphasis should be placed on adding "life to their years" not just "years to their life."

One cannot leave the discussion of chronic illness without mentioning its prevention. While certain psychological changes do take place with age, it is wrong to assume that disease is the unavoidable accompaniment of age. Many people, due either to ignorance or to lack of interest, do not make the necessary effort to prevent it. Periodic examinations, early treatment of minor ailments, and the observance of the known laws of hygiene would do much to prevent chronic illness.

The Student Nurse and Chronic Illness

ANNE BERNICE CONNOR

THE problem of the care of the chronically ill and aged is one which was accentuated by the war years. It is accompanied by considerable waste of medical facilities and fundamentally irregular handling of the sick. Long lines of chronically ill patients occupy the benches of our out-patient departments week after week. The lack of humanity in bringing these people back and forth from their homes is incredible but sometimes necessary with the present set-up, because there is no adequate visiting physician service to the patients' homes. They wait sometimes for weeks to be placed in a chronic illness institution which is always overcrowded and, in many cases, unsuited to their needs. The group of sufferers classed under this heading is very large and familiar to most of us. They include those who need little or no medical care, and those who require the best and most intensive care that can be given only in a modern hospital.

Providing satisfactory nursing service for these patients is a major problem. Chronic disease patients occupy many of the beds in our busiest institutions. Elderly patients fret away the long months in fracture beds; some become home problems because they grow incontinent; some are sliding downhill mentally as well as physically. Crowded old people's homes are ill equipped to care for persons needing practical nursing care and occasional medical supervision. The few nursing homes are not reasonably priced or publicly subsidized. Beds for convalescents have not even been considered in many community health programs and, in the face of this, the old people stay on, sweetly or whimperingly, month after tedious month.

Experience has shown that special chronic disease hospitals cannot satisfactorily conduct nursing schools and, as chronic disease patients are not generally cared for in other hospitals, most nurses have not received the efficient training they need, nor have the nursing needs of the chronic patient been impressed upon them. There is opportunity for the employment of all the arts and skills which a nurse may acquire in the relief of pain and suffering as well as to give the routine care which may be required. Resourcefulness and ingenuity have opportunity for very full development in such nursing. This manifests itself as the disease or age progresses and the various demands increase. Ingenious devices and pieces of equipment that never came out of a textbook are evolved from the nurse's brain and take their place as an important part of the environment. From a psychological standpoint, there is no field of nursing in which adequate training could be of greater value.

Nurses who care for the chronically ill should be intelligent observers, able to tell the difference between real and fancied illness. They must co-operate with the occupational therapist, the librarian, and others to see that the entire treatment is co-ordinated, to help maintain the patient's morale. They must possess real tact and firmness and, above all, an unlimited capacity for friendliness and kindness. It is hoped that some stress will be given in the schools of nursing to the needs and qualifications for chronic disease nursing.

The objectives which we have before us for achievement in this field include:

1. To promote the comfort and effectiveness of the chronically ill patient by the practice of good nursing based on a better knowledge of the nature of chronic disease and its effect on the patient and his family.

2. To learn how to promote health and prevent conditions which result in chronic illness.

There is now and the future will bring a greater demand for nurses in this field. Since demands for nursing in the community have a direct bearing upon what should be included in the curriculum in order to prepare the nurses for general service, it is time that this type of training was included in our regular programs. This service, when added to the services now provided, should contain the following:

1. Instruction in nursing general and specific chronic diseases. This should be both classroom and clinical instruction.
2. The history of geriatrics which would indicate the significance of the increasing life-span, premature senility, normal anatomic and personality changes expected in senescence, including the social and economic aspects.
3. The study of psychological problems involved in nursing chronically ill patients.
4. Methods of improving the patient's morale.
5. Occupational therapy which will foster a sense of usefulness and service in the aged.
6. A study of the resources available for recreation and occupational therapy in the community.

This outline of objectives provides educational subject matter which, with carefully planned guidance of graduate nurses, would permit rapid advances along these lines.

There is much of value from an educational standpoint in having a service for the aged and the chronically ill within the general hospital. Even better would be an affiliation with a hospital devoted entirely to the care of these patients.

With a systematic and well-organized teaching program, the educational value to the student can be limitless. Definite training in the methods of thinking, observing, and solving problems is provided. A gentler, more thoughtful, and more complete type of manual skill and habit of work may be developed. Ideals, attitudes, appreciations, and character values may be fostered, through such a course, that would be invaluable and encouraging to better nursing care for any and all types of patients. Enlarging upon these points, we might say, for instance, that, in the observance of symptoms, the most serious responsibility rests upon the nurse for frequently the patient cannot even speak for himself. In a hundred and one ways the chronically ill patient needs skilled watchfulness to protect him from conditions to which the patient in hospital for only a few weeks is never exposed. The gradual wearing down of resistance, making him susceptible to acute infection; the pressure of constant pain, which must be alleviated by medication with the resultant danger of habit formation; and countless other examples all suggest the necessity for skilled educated workers. Small victories are won over the enemy by preservation of healthy tissues and beating back "trophic lesions" or "pressure sores," as in the case of the helpless paralytic; securing moderate comfort for the arthritic by devising methods whereby movement is reduced to a minimum and by which painful joints may be cleansed and tissues kept in a healthy state; the ingenuity required to give a shampoo to a patient unable to move; the administration of medication, the carrying-out of treatments, the necessary surgical dressings, frequently present difficulties with patients of this type. Here again all the skill of the nurse may be directed to a successful adaptation of her knowledge. The careful planning of the diet necessitates understanding not only of nutrition but of the individual psychology of the patient, his background of race, society, and habit. It must not only nourish an undermined system, but must also be given under suitable conditions, not in haste, at a time when no physical or mental distress is present.

The nurse must have an insight into the spiritual as well as the psychological and physical needs of her patient. To know that one is on the last lap of the road is, to many, a great sadness which is oftentimes relieved by the quiet acceptance and determination to make the best of it in the philosophy of the nurse. Frequently the nurse in her ministrations is "ministered unto" by these patients

and is given to see how truly great a hero a human being can be in the midst of unspeakable suffering.

One outstanding thing that the student nurse learns while in this service is to teach the patient the art of living in bed. She does this through providing suitable activities, encouraging a hobby, interest or talent; broadening the horizon of the patient through reading material; teaching him carefulness while being careful herself; last, but not least, fortifying the patient with faith and the "will to live," in the belief that life, though handicapped, can be worthwhile.

Behaviour problems due to disposition changes come with old age and chronic diseases. These must be met with stabilization rather than restraint. The best tools for the purpose are persuasion and companionship. The patient's life is a lonely existence at best and must be brightened by cheerful neighbors and a staff with a sense of humor. Freedom, independence, privacy, quiet, and some sort of work will tend to make these people more happy.

The program of clinical instruction for student nurses in chronic diseases should consider, so far as possible, the capacity, needs, and difficulties in handling these patients. Assignments should be arranged in such a way as to provide for progressive experience and should be planned to develop and integrate theoretically practical and social aspects of nursing. It is believed that students would benefit most by having this form of affiliation during the last half of the second or in the third year of her training. During the first year she is being oriented to a new way of life and to nursing in general. She should have had junior surgery and medicine for a background in the care of the chronically ill and she should also have had some experience in a private or semi-private ward to get an understanding of contrasting cultural backgrounds of patients. She should have had some experience in the diet kitchen. Having her experience with the chronically ill and aged after these other experiences gives a logical order to the learning process by using knowledge and skill that the student already has and allowing her to benefit from the program at a time when she is ready for this progress. The desirable length of experience in this field should be from six weeks to two months and the work program progressive in educational value and responsibility.

The patient assignment method affords the opportunity of nursing a patient as a complete whole. The student learns to study the patient, to plan for the nursing care to meet changing needs, to relate mental attitudes to physical conditions, to realize the opportunity for social study and health teaching, to assume responsibility for the ill patient. This method simplifies the problem of supervision and evaluation of nursing care. In a hospital for chronic diseases the ratio should be one member of the nursing personnel to every three and one-half patients requiring nursing care. In the custodial section of such a hospital, which includes the aged who are well, one member to every six or seven patients is usual. Nursing personnel includes all persons who actually serve the patient—graduate nurse, student, aides, assistants, and orderlies. Of necessity, allowance must be made for fairly wide variations owing to changes in the nursing load as it is affected by the degree and number of convalescents. The patient assignment method is the most efficient means of stabilizing these variations.

In their declining years some people thoroughly enjoy living. Even though more or less disabled physically, they may be useful and influential. It is worthwhile to search for this secret before age gets the better of us. For those who are unfortunate enough not to have discovered it, the nurse of the future will be the one to whom they turn. The aged should be given all the assurance possible when the outlook is grave. Life means nothing when hope is gone and even old people may shrink from death.

Individual patients may present so few signs that nurses forget that they are ill. Their tendency to answer

such patients sharply is one of the liabilities connected with their presence on the wards of a general hospital. Chronic illness is not necessarily associated with old age, although the older the patient the more complicated his mental state and the slower his return to health. The chronically ill patient of yesterday was always a bit forgotten. Let us now prepare the nurse for the future according to the needs of these patients and not make the mistake of thinking that chronically ill patients are limited to those in advanced stages of senility, and cripples who do not need expert medical care and cannot benefit from it.

Occupational Therapy for the Chronically Ill

MURIEL F. DRIVER, O.T., REG.

THE care of the chronically ill entails more than routine nursing service. Both the physician and nurse will be quick to recognize the various psychological problems which may result from long periods of hospitalization. Both as a prophylactic and curative measure, occupational therapy is included when treatment is prescribed for this type of patient. It provides many mental and physical benefits and at the same time adds a note of normalcy to hospital life. Routine nursing care occupies certain periods of each day and the importance of this care cannot be minimized. However, there remain long idle hours in which the patient may do one of two things. His mind may dwell on his discomforts, both real and imaginary, and so undo much of the good work of his physician and nurses. He can direct his attention to an activity, mental or physical, selected and guided by the occupational therapist.

The therapist is, therefore, part of the team of workers whose aim it is to make the patient as comfortable and as happy as is possible within the hospital. It is not her desire to work as a separate entity, but rather to work in complete co-operation with the physician, nurses, and whoever else is concerned with the patient's welfare. If the patient is to receive full benefit of this treatment the therapist must have a sound knowledge of her patient's condition. This can be gained in three ways. First, by making rounds with the physician and nurse; second, by having access to the patient's chart; and, third, by frequent verbal discussion with the nurse. In turn, the other team members must also be informed as to what type of occupational therapy the patient is receiving. At Runnymede Hospital, Toronto, occupational therapy progress notes are recorded monthly on the patient's chart. The record does not consist merely of a report on the activity prescribed but includes the degree of co-operation, concentration ability, enthusiasm, and any favorable or unfavorable reaction to this form of treatment.

The occupation chosen by the therapist is merely a means to an end, serving as a "thermometer" on which can be read a variety of data concerning the patient's mental and physical condition. Poor work may indicate lack of manual skill, lack of concentration, poor vision, disinterest, loss of energy, poor co-ordination, or mental retardation. When planning the occupation program for a patient it is necessary to assess his capabilities and provide activities in which he can participate with pleasure and success. Frequently, his physical limitations will necessitate the adaptation of some equipment or tool, simpli-

fication of a design or technique, and careful selection of material. If the nurse understands the therapist's aim she can be most helpful by displaying interest in the project. A few words of encouragement from his nurse mean a great deal to the patient.

It is difficult to separate the mental and physical aspects of treatment. Seldom do we see the patient progress physically without a corresponding mental improvement. If the activity chosen for him serves to increase joint mobility, the patient's mental outlook brightens as he finds himself capable of increased activity. For those whose activities must be restricted, occupational therapy provides a controlled outlet for their energies. By encouraging them to centre their attention upon a craft project, we minimize their inclination to worry about themselves or their neighbors and we find them adjusting better to hospital life.

Mrs. X is a woman of seventy, confined to bed with a cardiac condition and diabetes mellitus. Before occupational therapy was prescribed, she lay in bed taking slight interest in the world about her. She was subject to frequent crying spells and talked continually of her physical discomforts. Although it was a month after the initial effort before the therapist was able to catch and hold the patient's interest, the gradual improvement has been very marked. Now we see her taking a most enthusiastic pleasure in her various projects and an active interest in her surroundings. She had never done any needlework before. Being left-handed, she felt such work was beyond her capabilities. Her first piece of simple embroidery on monk's-cloth was far from perfect but the bright colors gave a pleasing effect. Encouraged by her physician, nurses, and therapist she strove to improve this simple technique. In the first glow of achievement, Mrs. X was inclined to work too hard, tiring quickly. Since then she has learned to work more slowly. She began to experience again the spirit of competition, asking for some knitting like her neighbors. Here again her first efforts left room for improvement, which in due course was achieved. On one or two occasions, misunderstanding directions, she became emotionally upset over quite minor errors in her work. Gradually she is learning not to fret over such things. Usually this patient has two projects upon which to work. This means that if she finishes one before the therapist's next visit she has the second project to turn to. On other occasions this second project provides the change which is as good as a rest.

Mrs. X is still confined to bed but is in better mental and physical health. She displays a bright sense of humor and considers her sewing to be "medicine." We seldom hear much about her various symptoms. Her need for sedatives has diminished. A recent examination showed her to be wearing faulty spectacles. While waiting for the new glasses, she seemed to be troubled by headaches and dizziness. In an effort to relieve this, occupational therapy was discontinued for almost two weeks. At the end of this time she seemed so restless and unhappy it was deemed advisable to have her resume her activities in spite of poorly fitting spectacles. Since then she has been her usual happy self.

This patient's record shows a clear picture of the value of occupational therapy in treatment of the chronically ill. Our patient no longer has that horrible feeling of complete idleness and uselessness, and yet her new activities in no way interfere with the rest of her treatment program. Rather it would seem that occupational therapy is facilitating her response to the excellent care given by the other members of the hospital team.

Although about 70 per cent of the work of this occupational therapy department is done on the wards, there is a very definite need for the patients' workshop. This enables the more active of the group to participate in the crafts involving noise, space, large equipment, close and continuous supervision, and any degree of mess not suited to ward activities. For example, some of the male patients are weaving enthusiasts and by affording them the opportunity to spend the afternoon in the workshop they are able to do much of the setting up of the loom themselves and at the same time can have any assistance necessary when they want it. Later they can take the loom on to the ward to do the actual weaving. This means an increased feeling of independence

and pleasure in personal accomplishment. This workshop offers a sharp contrast to the atmosphere on the ward and we find some of the patients dropping in for a social visit, to see "what is going on." They frequently gather inspiration from seeing other patients at work and from the finished articles on our "Idea Shelf." During the early or latter part of the workshop period, when the room is emptier, the therapist frequently finds herself able to have a more private talk with an individual patient and so increases her understanding of her patient's problems. Sometimes this knowledge, shared with the nurse, can further benefit the patient.

In viewing the completed projects it can be seen that for the most part the articles are small, simple but attractive and frequently destined for some relative or friend of the patient. Over a period of time some patients show a marked improvement in their technique as their former skills return, co-ordination improves, or pleasure in achievement revives. When preparing projects for this group of patients, it is necessary to do more careful preparation than for a younger and more energetic group. Poor cutting of material can spoil the project and so discourage the patient at the start. At the same time it is essential to induce them to do as much for themselves as is possible within the limitations of their disability. It is well to bear in mind that as one grows older the eyesight frequently becomes poorer, manual dexterity may decrease, concentration, endurance, or patience may be diminished. In many instances these factors must be brought into consideration when we observe some of the more obvious manifestations of disease and disability. Another necessary point to consider in selection of the craft and materials is the ability of the patient to regulate wisely his own activity. It is necessary with some patients, such as cardiacs, to ration the materials carefully, leaving just enough to last until the therapist's return the next day. In some instances the quantity of material issued must coincide with the length of time deemed advisable for the patient to be occupied at one time. Still further consideration must be given to patients' tastes. Work that is familiar or that is guided by an awareness of the appeal of some of the more old-fashioned fads is usually more successful than if the therapist endeavors to impose more up-to-date ideas. This does not mean that the project need be unsightly or useless, or that the therapist should not be conscious of the value of variety. Rather it is essential to remember that the patient must be interested in his occupation if treatment is to be of real value.

In an effort to leave the control of "dosage" in the therapist's hands, still further co-operation must be obtained from the rest of the staff. They are expected to consult the therapist rather than the patient if they wish to obtain any of the finished articles, even if they supply their own material. This eliminates the possibility of the patients, who are capable of creating attractive articles, suffering ill-effects from undertaking too much.

This brings us to the question of an annual sale of work within the hospital. The advantage of such a sale is that the hospital disposes of any accumulation of work and can return the funds for further expenditures on materials. There are disadvantages in sponsoring such a sale because frequently the patients, aware of an approaching deadline, are tempted to be over-ambitious. Since we are presenting occupational therapy as a form of treatment and are striving to concentrate on the patients' welfare, it would seem to be poor policy to be forced to devote the considerable amount of time required in organizing such a sale, time which would be better devoted to the treatment of the patients.

Group projects, such as a hospital newspaper edited by the patients, can be of great interest, not only to the contributors but to the members of the group who are less active. The patients who find it difficult to participate in all the social happenings can

read about them in the newspaper and so feel that they are "keeping up with the times." Naturally such undertakings require tact to prevent some of the misunderstandings that sometimes arise when several people work together on one project, particularly when the participants have a variety of individual experience.

Although many of the patients have frequent visitors there are many evenings that seem too long. The therapist should arrange a variety of entertainment to fill some of these periods. By using the evenings during which there are no visiting hours the nursing staff is not confronted with too much increased activity and all patients able to attend are free to do so. The selection of entertainment must be governed by the volume of sound and the degree of excitement likely to be aroused. The variety of tastes encountered in a group, such as will be found in a hospital of this kind, is bound to be fairly wide. However, the favorite programs seem to be movies, sing-songs, musical evenings of a simple form, and games. Local volunteer organizations can be appealed to to supply one or two programs each month. It is wise to remain in close contact with these groups and guide their selection of entertainment. The games evenings can be organized by the therapist who would rearrange her daytime program to make this feasible. The games should not be too complicated but within the capabilities of the majority.

When the occupational therapist considers her entire program for the chronically ill she must realize the challenge this group presents. These are not patients to be fitted into neat little mental pigeon-holes and dealt with in a stereotyped manner. Many of them present long histories of illness and hospitalization and there is a strong possibility of psychic trauma resulting from such an abnormal mode of life. It is necessary to be constantly aware of the patient as an individual personality whose importance is in no way lessened because he has been admitted to hospital accompanied by a certificate of incurability. With the younger members of this group the question of re-education arises. What does or will society do to broaden the scope of those capable of some form of remunerative occupation? If society is doing or is going to do something for these patients, the therapist must be ready to make her contribution. From observing the patients under her care the occupational therapist gathers information regarding work habits, reliability, endurance, and general aptitude. She can start the re-education process by bringing her patient to the stage where he is ready for industrial or commercial training. He must first learn the pleasure of accomplishment and the value of sustained effort. Conscious of all the ramifications presented by this field of medicine the occupational therapist finds stimulation and satisfaction in her work.

With UNRRA in Germany

LYLE M. CREELMAN

BROADER HEALTH PROGRAM

AS THE MOVEMENT of DPs from place to place grew less, and the population of the assembly centres became more or less stationary with the approach of winter, a broader health program was possible. Moreover, having the communities fixed made it easier to establish and to coordinate health and nursing services. As in any health service in any country, the greatest return for the effort expended resulted from work with mothers and young children. To most of them, any form of health education was quite new, but, as they became convinced that their children would benefit, they were most eager to take advantage of the offers. At the outset expectant

mothers were very reluctant to report for examination but, when it became known that extra milk was available if a card showing regular attendance at the clinic could be produced, and also that material for a layette would be provided free, the majority came to the prenatal clinics. In most assembly centres, the nurse arranged a rest centre to which mothers might return for a few days after discharge from hospital, and before taking the baby back to the crowded communal quarters. During that time the mother had extra rest and was taught how to bathe and care for her baby. The most attractive of all these centres, and the one in which the best teaching was done, was staffed by two conscientious German nurses. The DP mothers showed no hesitation whatever in entrusting the care of their babies to these nurses — why should they, indeed, when the obvious mutual interest was the welfare of the child? Baby clinics were organized wherever possible, and attendance increased gradually until a very large percentage of the mothers with young babies were coming to receive advice from doctors and nurses. So far as could be determined the infant mortality rate was about 80, which compared very favorably with a recorded rate of 140 in Poland in 1939.

The development of special feeding facilities for children was a chief responsibility of the "Relief Services Personnel," the doctor, the nurse, and the welfare officer. In nearly all centres a children's dining-room was established, in which the children had at least one meal a day. Other meals were taken in the living quarters with the rest of the family. Those circumstances made communal lodging and some overcrowding very common. Communal feeding was not common, most of the DPs preferring to obtain their own rations and prepare and eat their meals in their own rooms. This method was encouraged wherever facilities permitted it, as it helped to maintain the family unit. The rations provided permitted only a daily calorie rate of 2,400 which at one time was reduced to 2,000 and, ultimately, slightly lower. There was never an adequate supply of milk. Fresh fruit simply could not be provided, and fresh vegetables, except in season, were very difficult to obtain. A great deal of bartering went on between the DPs and the neighboring farmers wherever this was possible. No scientific nutrition studies were made at the outset, but several careful surveys were subsequently conducted to determine the degree of nutritional lack. From the appearance of the children, one would expect that a high percentage suffered from nutritional anemia, but investigation showed that the distribution of frank nutritional disorders was by no means uniform.

One of the outstanding difficulties was the lack of facilities for the diagnosis and treatment of tuberculosis. The incidence of the disease was not determined. It was commonly regarded as high, as a result of the living and working conditions under the Nazis, and it was considered that the overcrowding in the DP camps was conducive to rapid spreading. Actually, when a survey was made at Belsen, where it had been expected to find as many as 50 per cent affected, the results were amazingly low; but there is no doubt that a considerable degree of tuberculosis existed. When a case was diagnosed and hospitalization recommended, it was most difficult to persuade the patient to leave his family and go into hospital unless, indeed, he really felt extremely ill. When he did go, his family frequently went with him, and nearly all hospitals had a very great number too many on their books.

The incidence of venereal disease was also unknown, as there was no compulsory examination, and the treatment, due to lack of penicillin, was antiquated and inadequate. Known cases were under treatment for long periods, during which time they occupied much-needed hospital beds.

Except for tuberculosis and venereal diseases, the incidence of communicable disease was relatively low,

and was much less than the rates among the German population.

The question of excessive admissions and failure to discharge from hospital convalescents and persons who could not be justified as bed patients presented a difficulty. Many doctors and nurses, whose sympathies were seized by stories of the sufferings of the DPs under German rule, were easily persuaded to allow relatives and friends to remain in hospital with patients and, at one time, the percentage of "patients" hospitalized was three times as great as could be justified on the statistics of bed provision for any ordinary, or indeed any poor, community.

The organization of the assembly centres was a matter of growth by trial and error, but ultimately became quite effective. The assembly centres which operated most efficiently were those in which the UNRRA team director and his staff were able to organize the displaced persons in such a way that their elected leaders did the actual work, leaving to the UNRRA personnel the necessary official contacts with the military authorities and general overall supervision and guidance.

Health Committees

As a health group, we were slow to make use of DP health committees. Perhaps this was because there were so few trained DP personnel. Many had suffered from so much deterioration of morale, and there were so many things that had to be done immediately as matters of urgency, that it seemed easier — as it always does — to do it oneself. However, when there was time to think about developing the health education aspects of the program, committees were formed with very gratifying results. Reference has already been made to the services provided for mothers and children. Much assistance was received from DP health workers. One of them was usually appointed for each camp, or for each block of buildings, and had the duty of visiting every room to check the sanitation and reporting any cases of illness to the UNRRA nurse, who would then visit and take any necessary action. This method proved very effective because the DP mothers were far less likely to hide sick children from one of their own people than from an outsider. The health worker was often able to explain the nursing service and so allay unnecessary anxiety. She was also able to show the reason for the use of protective foods and medications, and supervise, for instance, the distribution of cod liver oil. Though supplies of this commodity were extremely short and sought after most earnestly by the civilian population outside DP camps, it was hard at the beginning to show the DPs how essential it was that their children should receive what little was available. Many of them, indeed, considered it much more sensible to use cod liver oil as a grease for shoes than for internal consumption!

The activities in the camps, which began as social services of a somewhat scattered nature, ultimately extended to the whole of the internal administration, with a strong empasis upon medical and nursing care and social welfare.

Administrative Structure

As previously mentioned, the third point in the UNRRA program was to build up a proper administrative structure. The country was divided for military control into corps districts, eight corps having the area from the Danish border through Schleswig-Holstein, thirty corps extending from Brunswick and Hanover across to Holland and Belgium, and one corps taking in the southwestern remainder of the British Zone of Occupation. Central headquarters, as stated, was at Bad Oyenhausen, and ultimately distributed in several of the less-damaged villages around Minden, Herford, and Bielefeld, particularly in Lubbecke and Bunde.

The Zone Director for UNRRA established his headquarters at the beginning of August, 1945, in the village of Spenge, from which it was transferred to Lemgo in the second week of June, 1946. The headquarters

unit of UNRRA was established in close relation to the headquarters unit of the army and, subsequently, to the Control Commission for Germany. Under this UNRRA Zone Headquarters there were three UNRRA district headquarters corresponding to the three army corps mentioned above. In each army corps area there were set up three to six field supervisory headquarters, the number depending on the urgency of the problems, the number and location of assembly centres in the district, and the total number of displaced persons for whom provision had to be made. For each assembly centre there was an UNRRA team and, when the organization was built up in the late autumn of 1945, there were 210 centres for some 600,000 DPs.

At each administrative level there was a chief administrative officer and his administrative staff. The organization of medical, nursing, and social or welfare services — together known as the "Relief Services"— followed the same pattern. Overall control rested with Zone Headquarters. Since the team was the unit in the field and actually the oldest established service, there was at the outset considerable difficulty in co-ordinating activity. There was some opposition to the appointment of a supervisory nurse at the field level. Field administrative officers could not visualize any function that required the services of a supervisory nurse, while many of the team nurses preferred to carry on in their own way without a supervision that they considered would be "outside interference." Great credit is due to the field supervising nurses for their quiet but determined, and ultimately successful, demonstration of the value of supervision. They were able to distribute and allocate the nursing personnel, drawn from both UNRRA and displaced person groups, to the best advantage. They stimulated and guided the nurses, many of whom were not trained in public health or in the appreciation of a public health program. They developed staff education and an *esprit de corps* through regular meetings and, in fact, they used all available tools of supervision to encourage the team nurses to provide the best possible nursing service in the interests of the displaced persons and of efficient administration generally. To many of the UNRRA nurses this was an entirely new approach, and they learned from it many principles which it is hoped will be of value to them in the years to come.

UNRRA Nursing Teams

When I first arrived in Germany early in July, 1945, the UNRRA nursing staff totalled 104, of whom 19 only, (18 per cent), were of English-speaking nationalities. By the end of November, 1945, recruitment had brought our numbers up to the highest peak attained, 211 of whom 29 per cent were of English-speaking nationalities. Among these were sixteen Canadians and seven American citizens. On the staff there were nurses from twelve different countries. It was a most valuable and interesting experience to observe the differences in professional background displayed, and to try to develop, with such a mixed staff, more or less uniform nursing service and nursing standards. The majority of the non-English-speaking nurses had, however, the advantage of being able to speak German, which was the language most commonly used in conversation with the DPs. Nevertheless, it was notable that language was little handicap after a few weeks or months, as the staff very quickly learned a sufficient number of words to ensure understanding.

Looking back on this experience, I think it was probably the team nurse who gained most value from service with UNRRA. It was she who had the satisfaction of doing the real job for the DPs; of having the close contact with them that was so interesting and revealing; and of knowing that her services as a nurse were actually helping to relieve the suffering, or to rehabilitate people who had already suffered and lost so much.

Nursing for UNRRA was not an

A nurses' aide class in Germany

easy task. In addition to good professional qualifications, the nurse had to be a person willing to undergo cheerfully many physical discomforts and to meet many emergencies with calmness and assurance. She had to be able to assess the total needs and to decide which among them was a "priority." In the beginning, there was so much to do that it was certainly a case of doing the most essential things first. It has been mentioned that in the early days many of the DPs were still on the way home, and there was a continuous movement of populations from camp to camp — some going out, others coming in; some searching everywhere for friends or relatives; others grouping themselves with those who spoke the same languages or came from the same provinces. The first thing the nurse had to do in this changing scene was to find helpers from among the DPs themselves — preferably, although all too rarely, qualified helpers — who would have sufficient stability to undertake nursing aide work and to "stay put." Usually there were some women or young girls who had had some experience that was valuable, and these were particularly useful in the sick bays that were set up in every centre.

Nurse Aide Training

As it was an UNRRA objective to help people to help themselves, it was in order that DP personnel should be utilized to the greatest extent possible in the health program. In many assembly centres team nurses organized classes and gave instruction to girls and women who were interested, so that they could be of greater service. In addition to this program, which was very valuable but which was, in the main, uncontrolled and lacking any uniformity in standards, there ultimately grew up from it training courses for nursing aides. These courses were developed by the deputy chief nurse, Miss Norena Mackenzie, also a Canadian, who later on in London was appointed special instructor for the course given to graduate nurses from many countries receiving UNRRA aid.

The purposes of our program were to provide extra assistance in the camps and assembly centres and also to encourage young women, who had the required qualifications, to develop an interest in nursing, so that, on return to their home countries, they might enter a school of nursing and become fully qualified nurses.

One of the first centres established was for displaced persons from

the former Baltic States. Five centres were opened for Polish girls, although both groups were sometimes represented. Well-qualified UNRRA nurse-instructors were selected for the teaching and, where necessary, an interpreter was provided. It may be mentioned that the fact that instruction had to be given through an interpreter did not seem to lessen its efficiency. In these cases lessons had to be prepared most carefully and the presentation made as simple as possible, with few words and much demonstration. This, together with the necessity of clarifying and crystallizing the ideas of the teacher, usually resulted in better teaching.

By the middle of June, 1946, 192 nurse aides had taken the six weeks' course, and had received a certificate printed in two languages — English and Polish for the Poles, and English and German for all other nationalities. We were careful to state on the certificate that the holder had not taken a course qualifying her as a nurse, while the subjects studied and the time spent on each were listed on the back of the certificate. Although, at the time, we were a little concerned about the necessary shortness of the course, we found on returning home that the training given was much more adequate than that given today to the majority of so-called nurse aides in many of our Canadian hospitals. The courses established at this time have been continued and, up to the present, well over three hundred girls have attended.

In order to give better preparation to the limited number of DP qualified nurses so that they might take over full responsibility for the nursing service as UNRRA nursing personnel was reduced, a refresher course of ten weeks was planned. Again, the first to be established was one for nurses from the Baltic States, since there was a relatively higher proportion of qualified nurses among this group. Some difficulty was experienced in finding candidates from among the Poles, who were both qualified professionally and willing and interested enough to take the course. Up to June, 1946, not a sufficient number of Polish candidates had been obtained, but I am informed that later a group was assembled, although not all were fully qualified.

We were very proud that the British Zone was the first zone in which the nursing service organized a training program for nursing aides and refresher courses for the qualified DP nurse group. It was one of the most worthwhile of all the nursing activities.

(*to be concluded*)

In Memoriam

Katharine Grace Campbell, who for many years was associated with the Edmonton Board of Education as school nurse, died recently in Toronto.

Mrs. Christina Ann Conklin, who graduated from the Winnipeg General Hospital in 1897, passed away recently in Vancouver.

Rowena Hamblin and **Jane Warren,** student nurses of the Vancouver General Hospital, were among the passengers lost aboard a T.C.A. airliner early in May. A memorial service for them was held at the request of their fellow nurses and associates from the hospital.

Mrs. Carolina Johnson, a former matron of Royal Columbian Hospital, New Westminster, died at the end of April at the age of 80 years.

Mary Martha Kilgour, who graduated from the Toronto General Hospital in 1893, died in Toronto on June 7, 1947. In 1909, Miss Kilgour joined the staff of the Toronto General Hospital as assistant superintendent of nurses. Two years later she was appointed lady superintendent of the Maryland General Hospital, Baltimore, later becoming superintendent of the Home of the Friendless in that city. She retired from active duty in 1931.

INSTITUTIONAL NURSING

Contributed by the Committee on Institutional Nursing of the Canadian Nurses' Association

Job Analysis

MARION E. BOTSFORD

THROUGHOUT Canada and the United States, during and following the war years, more and more stress has been placed on the value of sound personnel policies in employment of industrial as well as professional workers. In order to make a more scientific approach to personnel practices, such terms as "job descriptions," "job analysis," "job specifications," "job evaluation," etc., have become common usage. Although these terms are not, perhaps, as familiar in Canadian hospitals as in industrial plants, the Institutional Nursing Committee of the Canadian Nurses' Association has recently undertaken a study of job evaluation techniques and is now preparing a guide for the use of such practices within the nursing field. In order to take advantage of techniques already in use, a nurse observer was asked by the committee to spend some time with Job Analysts in an industrial institution which has developed a system of job evaluation within its personnel department. The following information regarding the process of job analysis is based principally on the observations made under the direction of these analysts.

Before discussing the details of job analysis it will be necessary to place this process in relation to the whole subject of job evaluation, which is the method of rating a particular job in relation to other jobs within an organization. The purposes of job evaluation include: the determination of an equitable salary structure; indication of a logical sequence of promotions; assistance of management in proper placements of staff for the various jobs required; and indication of the types of instruction and training which may be of benefit to all employees.

The plan of job evaluation is divided into three distinct phases:

Phase 1—Obtaining all available information about the jobs and writing job descriptions.

Phase 2—Rating the jobs according to a pre-determined scale to establish a "point value" for each job.

Phase 3—Applying a new wage scale to jobs according to "point values" determined in Phase 2.

Our purpose in this article is to discuss Phase 1, or job analysis.

The Washington War Manpower Commission defined "job analysis" as follows:

> The process of determining, by observation and study, and reporting pertinent information relating to the nature of a specific job.
>
> It is the determination of the tasks which describe the job and of skills, knowledge, abilities, and responsibilities required of the worker for successful performance and which differentiate the job from all others.

One of the most important aspects of job analysis, and one which should be kept in mind constantly, is the fact that it is an analysis of the *job itself* and not of the person on the job.

If a job evaluation plan is to

be a success, in an organization of any size, the detail work should be done by a competent specialist on full-time. Job analysis and evaluation is technical work, and high ability and skill are necessary for a satisfactory result. Trained analysts may be brought into an institution to conduct an analysis, but it has been found of greater value to train personnel for this work from within the organization concerned. Although such persons may not be able to ignore completely the present incumbent on the job, this disadvantage is not serious, particularly as the analysts gain greater understanding of the process; and it is outweighed by a better insight into the various ramifications within the institution. It is suggested also that there should be one or two associate analysts so that two or three independent judgments can be used to reach decisions. These may be drawn from other departments when jobs are to be valued.

In undertaking a job evaluation procedure in any institution, an intensive educational program should be conducted first in order to assure a complete understanding, by executive and staff alike, of the objectives and the results expected of such a program. The complete co-operation of all concerned is a vital requisite for its success, and this is only obtained through an appreciation of the value of job evaluation.

After the plan has been well publicized and everyone understands its purpose, the analysts select one department in which to commence their work. The first step is to ascertain, as far as possible, the number of job titles in the department. This information is obtained from the department supervisor and may or may not be accurate, as what are considered like jobs, when analyzed, may be found to be quite different, while others may be considered as two different jobs and be actually only one.

An "Individual Job Description Form," with instructions, is then distributed to the personnel of the selected department. This is a questionnaire prepared to meet the needs of the particular institution concerned. When completed it contains the following information: employee's name, payroll title, name and title of immediate supervisor, name and location of department, and the date. Questions regarding the following aspects of the job are to be answered and space is provided for the answers:

Description of daily, weekly, and monthly duties.

List of daily, weekly, monthly, and semi-annual records and reports.

List of machines, equipment, and supplies used. Description of unusual equipment and its method of operation.

Proportion of time spent in standing, sitting, walking, lifting, climbing, etc.

Supervision of other employees, indicating nature of supervision and number supervised.

Employee's opinion regarding most complex or difficult part of her work.

Description of conditions present in location and nature of work, such as surrounding, dust, temperature, monotony, working under pressure, lack of co-operation of other departments, etc., which is considered unfavorable or disagreeable.

List of additional duties.

Before distributing these forms it is suggested that the analysts discuss them in detail with the whole staff, and that they stress the point that they are not concerned with personal performance on the job in any way, but solely with the actual duties.

When the questionnaires are completed and returned to the analysts, they are reviewed and then discussed during a personal interview with the individual employees.

When this form is distributed to the employees, a "Job Classification Questionnaire" is given to the supervisor. A separate form for each job title is necessary. It is suggested that the analyst discuss this form in detail with the supervisor and, if possible, actually complete it during the discussion.

The "Job Classification Questionnaire" contains the following information: payroll title of position, name and title of employees' im-

mediate supervisor, name and location of department, names of employees occupying the position and the date.

The following information regarding the minimum requirements desirable for each position is requested: (It is noted that this does not mean the qualifications of present employees unless these agree with the supervisor's opinion of the minimum requirements.)

Minimum formal education or its equivalent.

Special courses or specialized knowledge.

Previous work experience — its nature, where it can be obtained, and minimum time required to acquire it.

New factors to learn on the job, and length of time required to learn them.

Physical requirements, such as sex, height, strength, eyesight, etc.

Maximum and minimum age requirements.

Undesirable or disagreeable aspects of position.

Number of employees supervised by employee in this position and nature and extent of supervisory responsibility.

Nature and extent of responsibility of job for materials, machine, methods and procedure, records and details, etc.

The most difficult part of the work to teach a new employee.

Positions within the organization from which employees could be promoted to this position.

Higher positions within the organization for which this job should train an employee.

Positions to which the employee could be transferred in the event of reduced activity.

When the above-mentioned forms are completed and returned to the analyst, he is then prepared to write job descriptions. A form is used for this purpose which makes for uniformity of all job descriptions and the material is taken from the employee's and supervisor's questionnaires.

The job descriptions are written under the following headings: job summary, work performed, equipment and supplies used, mental requirements, skill requirements, responsibility, volume and complexity of duties, resourcefulness, working conditions, physical requirements, relations to other jobs.

A card containing a résumé of this material may be prepared for the use of the personnel department. Such cards are useful in conducting interviews with applicants for positions.

If outlines of the duties of each job are prepared and kept in each department it facilitates the completion of the employee's and supervisor's questionnaires. On the other hand, if such outlines or manuals are not already in existence, they can be readily compiled by making use of the job descriptions prepared by the job analyst. One manual which was observed in a large business concern used such headings as, "the WHAT of my job," "the WHEN of my job," "the HOW of my job." Complete information regarding the duties required in this job was noted, and the manual was reviewed every six months and revised by the employee when necessary under the guidance of the department supervisor. These job outlines contained in the department increase the efficiency and save time for the present employee and greatly decrease the learning time on the job of a new employee.

Analysis of many job descriptions indicate that there are overlapping elements, many of which can be grouped together under headings indicative of their similarity. In practice it was found necessary to reduce the number of such groupings or factors as far as possible. The five main factors usually employed are: mental requirements, skill requirements, physical requirements, responsibility, working conditions. These may be further broken down into their component parts. For example, skill requirements may be divided into: education, previous experience, training time, versatility, and quality. Each factor is given a number of points and is weighted in relation to the other factors according to the nature of the organization concerned. Each sub-factor is broken down into degrees with an increasing point value for each degree. For example, the sub-factor of education may be given ten points and divided into six degrees as follows: (1) Grade

8 (0 points). (2) Grade 10 (2 points). (3) High school graduate (3 points). (4) High school plus business or vocational training (5 points). (5) University graduate (8 points). (6) University plus technical courses (10 points).

The names applied to the various factors can never exactly cover the scope of one factor. For this reason, simple, understandable, and brief definitions of the scope of each factor and sub-factor must be prepared.

When all factors are broken down, clearly defined and weighted as to point value, a rating scale can then be prepared containing this information. This is the yard-stick or measuring device against which all jobs are measured.

To complete the job evaluation process from this point, each job is rated and placed in relation to every other job. This is done by a rating committee which is comprised of the job analysts, one or two people on the job to be rated, a supervisor, and such other people as deemed advisable. All jobs are measured against the rating scale and given a "point value." When all jobs are rated, a new wage scale is applied according to the "point values," and includes a spread to make allowance for personal performance on the job. This is done by a central executive committee.

There are several methods used in evaluating jobs and in conducting a job analysis. All, however, attempt a scientific approach to wage and salary administration, and have proven of value in personnel work.

In applying such methods to nursing, other results might also be expected which should prove helpful. Among them the following could be anticipated and should be worthy of consideration:

1. A complete, accurate, and impersonal description of all classes of work within the nursing administration.

2. Job information in convenient form for use in making new appointments, promotions and transfers.

3. Guidance in rating of employee performance.

4. A basis for the preparation of work manuals, thus decreasing the length of the adjustment period for new employees, and increasing the efficiency of present incumbents.

5. Assistance to supervisors by familiarizing them with the work expected of their staff.

6. Disclosure of unnecessary routine and duplication of effort.

7. Provision of a basis for improved organization of nursing personnel and division of authority and responsibility.

At this time of acute shortage of nursing staff, continuous staff changes, and requests for salary adjustments, such a scientific approach to personnel practices should be of considerable value. In industrial and business concerns where job evaluation programs have been carried out and new wages scales put into effect, outstanding results have been obtained in increased efficiency and production, better co-operation, and greatly decreased turn-over in staff. Such results would undoubtedly be of value in the nursing field.

War Memorial Trust Fund

Our pride in the meritorious record of the Canadian nursing sisters is symbolized in the cover picture which depicts the Governor General, Viscount Alexander, pinning the Royal Red Cross on **Lieut. (N/S) H. T. Morrill** of Fairville, N.B. Tangible evidence of our pride will be found in the donations to the War Memorial Trust Fund for the purchase of libraries of professional books to serve the nurses of the devastated lands. The total is growing slowly but it needs the combined interest and energy of nurses in all parts of Canada before we will be anywhere near to the original objective of $32,000. The following figures represent the total donations, to date, by provinces: Alberta, $1,022; British Columbia, $705; Manitoba, $1,959; New Brunswick, $680; Nova Scotia, $401; Ontario, $3,803; P.E.I., $80; Quebec, $378; Saskatchewan, $744; Anonymous, $8.00 — Total: $9 780.

Have you made your donation yet?

Contributed by the Committee on Public Health Nursing of the Canadian Nurses' Association

Outpost Nursing — A Challenge to Canadian Nurses

MURIEL I. SCHONBERG

OUTPOST nursing of the future will be a far cry from the grim epic of little log shacks and heroic nurses confronted with desperate emergencies and overwhelming situations. The word "outposts" is a misnomer, leading one to visualize endless snow and long hard trips by dog-team while, in reality, any community twenty-five miles from a medical centre, hospital, or doctor is a medically unsupervised area. Babies are brought up by rule-of-thumb and mothers neglect prenatal visits because of rough roads and time-consuming trips. Minor defects, unless discovered during a chance visit to the doctor on some emergency mission, are ignored; babies come into the world without benefit of medical help and mothers drag around with neglected gynecological aftermaths in consequence. Malnutrition, rickets, and appalling dental conditions thrive in conjunction with shelf upon shelf of patent medicines at the general store, while one day's perusal of back files on health queries in the farm papers should make all connected with the medical profession writhe with shame at the discovery that it is necessary in this enlightened day and age, for any person to have to resort to such a source of information.

Since it is admittedly impossible for an impoverished small community to support a doctor, it follows that the nursing profession can contribute by sending specially qualified nurses to such isolated communities, thus bridging the gap. The outpost nurse is called upon to fulfil many functions, beginning with prenatal care, occasionally baptizing the asphyxiated infant, not infrequently playing hymns for a funeral or reading aloud prayers for the dying in half a dozen different faiths. These are unexpected qualifications, but the nurse is often the only educated individual in the community and, however little she knows about a subject, she can usually contribute a little more than anybody else. This is very well illustrated by a note handed in to me as I write:

Nurse — Our cow doesn't seem to make her water very good. What can we give her, and is the milk fit to use?

Veterinary knowledge comes with the years and home visits to well-run farms contribute greatly to a store of information which can, of course,

Ready for work

be casually passed on at the right moment to less enterprising homesteads. The free booklets on cattle, swine, and poultry, from the provincial department of agriculture, will usually clear up a mysterious complaint as together the farmer and the nurse study the index. Here, a knowledge of medical terminology will help. The farmer will in future know where to look for information and the nurse is left to reflect that the ailments peculiar to pigs and cows are not vastly different from human ailments and appear to stem from the same sources — malnutrition, lack of sanitation, and lack of cleanliness.

The first home visits in a new district are shattering in their revelation of ignorance and apathy in matters pertaining to health. Nor does the pattern vary to the slightest degree in any province of the Dominion. Such visits require sympathy and diplomacy and they are never hurried. You may shudder to see the nine-months-old baby chewing a piece of rancid-looking salt pork, liberally smeared with dirt from the board floor or, in Indian settlements, a muskrat tail. You listen, outwardly calm, to tales of croup and convulsions and encourage the mother to talk of the remedies used; cow-dung, urine, and spittle play a large part in the remedies of the more primitive outposts — by no means confined to Indians. Anything so simple as a compress, after the time-honored remedy of a cow-dung poultice, lacks dramatic force, so it is never advisable to suggest it as an alternative, in conversation at least. An opportunity will arise before too long to give a practical demonstration of its simplicity and effectiveness. After all, Antiphlogistine can be substituted without too much loss of prestige. But, even while outwardly acquiescent, she is imagining in place of a pallid, rickety baby lying behind the kitchen stove, sucking a bottle of cold formula of undetermined composition and origin, a rosy-cheeked supervised baby, lying in the garden and fed correctly at regular intervals. If you have won the mother's confidence she will tell you the story of the baby's birth and, more often than not, about her difficult pregnancy and labor. If there were time to recount the thousands of stories such women have told with the simplicity of truth, you, too, would spare no efforts to bring about prenatal care for each and everyone, and make possible safe childbirth for every mother in Canada. If no doctors are available, then the trained hands of a nurse-midwife should be. The reason for the home visit may well be the result of a school inspection, a grand piece of strategy for gaining an entrance to every home. Who can resist the interest shown in the children of the family? School visits are the vital part of a well-planned campaign to capture the interest of the school children in healthful living, by combined instruction of parent, teacher, and child.

Often the children are fed inadequately. There is no doubt that farm children suffer greatly in this respect. The children are allowed to live through their school days in a filthy, verminous condition, with scabies, impetigo, or neglected sores. They are allowed, in addition, to mingle freely with unchecked, undiscovered tuberculosis. Finally, when communicable disease hits the community, they drag themselves through a neglected illness and suffer all their lives the sad consequences of deafness, impaired vision or hearing, and crippled limbs.

The boil and other indications of a lowered resistance, sore enough to drag a man to his nearest doctor, are but a part of the picture. There is no one to tell the doctor that the family have had no garden, that they share one can of Carnation milk a day, including the baby's share, that they prefer white bread, salt pork, and pastry to anything thought up by the Department of National Health. Only a public health nurse has the time and entrée to the patient's home to deal with such problems, and to differentiate between conditions requiring immediate medical care by a doctor, and simple situations requiring good teaching.

There is no set procedure for the duties of a public health nurse. Every situation demands its own treatment, thus creating as varied and free a life as can be found anywhere in our profession.

After thirty or forty follow-up school visits, a picture of the health habits of the community can usually be obtained and program mapped out to meet their needs. If maternal and infant mortality exceeds normal, this could be the first campaign. Tuberculosis is not usually an overwhelming problem in the western provinces, thanks to the active preventive measures taken by the departments of health, the accessibility of free x-rays and mobile clinics, and their careful checking of all contacts. It is, however, quite another story among the Indian population and the provinces of the east. The percentage of defects is usually high, both in school children and in adults, and this is a heavy burden in any new district. Children with diseased tonsils have low resistance to respiratory infections and provide a lively source of infection for the rest of the school. Children with eye defects are often maladjusted, while abscessed teeth and chronic, discharging ears are only too common. The children and their defects are not the only problem. Neglected hernias, chronic appendices, or enlarged prostates sap the energy of the bread-winner. The nagging, scolding wife all too often reveals a chronic backache "ever since my first baby was born," and confesses shamefacedly "something hangs down outside her" which, being interpreted, usually means prolapsed uterus and its accompanying cystocele and rectocele. All this remedial work is a prelude to the future of a healthy physically fit community. Nothing should be too trivial for the nurse, for if the people feel free to come to her for small things, she will certainly be able to influence them in matters directly pertaining to their health and welfare. This is, naturally enough, very time consuming and could not be attempted in an organization with set duties and a time limit. The outpost nurse has very little bedside nursing, since distances are far too great for daily nursing care. If she existed solely to nurse the sick, her more important function of teaching the community how to keep well would inevitably be relegated to a spare-time activity.

Another mode of transportation

There are, roughly, two approaches to outpost or district nursing. The old idea was to have a nurse available for emergencies and illness. In the new approach she is responsible for the health of the community. The very ill patient should be nursed in hospital, for he requires expert attention twenty-four hours a day. This would be an impossibility in an outpost where one nurse is occupied with several hundred families. She can, however, train women who are free to be called upon in times of illness and childbirth. Many hospitals will help in this task by supplementing the classes held at the nursing station by a few weeks practical work as nurse's aide. With two or three such women in the district, it is possible to feel secure in the knowledge that a newly-delivered woman living twenty miles from the nursing station will not be left to be tended by a hastily instructed relative. Apart from childbirth, and chronic illnesses of old age, a well-run district should produce little more than surgical emergencies and accidents. But to bring about such a metamorphosis means at least two years of relentless effort and teaching by demonstration, precept, and example. Adult education classes, mothercraft and home nursing groups, films, filmstrips, posters, school lunch

programs, visiting experts in cookery and handicraft, and animal husbandry are only a few of the means employed.

The above program sounds formidable, but it must be remembered that little more than general knowledge and common sense is required, provided the nurse's preparation for outpost nursing has been adequate. It cannot be emphasized too strongly that teaching in the majority of outposts is of the most elementary nature. Generally speaking, the more backward and primitive the community, the more ingenuity will have to be used to convince the people. For instance, in a halfbreed settlement, an experiment using four white rats produced a change of attitude, which two years of constant teaching had failed to provoke. The first pair were fed the children's own diet of bannock, lard, and boiled black tea without milk. The second pair received a more balanced diet which could easily be obtained locally, plus cod liver oil. The experiment had been planned for the children, but there were so many adult visitors that it was necessary to put the rats in the waiting-room of the office, where they caused a sensation, to say the least! That gruesome film, "The Housefly," and a gallon of DDT donated by the Red Cross and distributed free to the most fly-ridden houses, did more in a few days to convince the unbelievers in another community than years of weary reiteration could possibly have accomplished.

This is but a glimpse of the service that an outpost nurse can render to Canada. Every thinking man or woman must realize that if we are not to be crippled in the future by the general physical unfitness of thousands of men and women whom we have made little or no attempt to serve in the past, we must without delay meet this challenge. There is abundant evidence that the lone trail of the outpost nurse is about to end.

The new and vital interest in Canada's lonely places shown by the Federal Department for Indian Affairs and the Canadian Red Cross has already demonstrated that this stepchild of the nursing profession, abandoned, neglected, and deserted, but for the missionary efforts of the few, is in fact about to blossom into a veritable "Cinderella," with electrically lighted homes and modern bathrooms to replace the haphazard living accommodation of the past. Radio communication and flying ambulances will space the terrifying gap between hospital and patient. The Northwest Territories are already mapped for strategically placed hospitals, equipped with a medical flying unit capable of moving patients to hospital at the radio request of the outpost nurse. The Red Cross, in several provinces, has built attractive homes, specially planned and equipped for outpost nurses, and, in addition, provides generous salaries, living expenses, and holidays with travelling expenses to headquarters.

It is not the purpose of this article to serve as a glamorous piece of recruitment propaganda, but rather to draw the attention of Canadian nurses to the new phase of Canadian nursing history which is about to commence. Before long, provided that the attention of the profession is aroused, steps will be taken to ensure the adequate preparation of would-be outpost nurses. In addition, conditions under which such nurses serve will be so attractive that, in return, we may expect an extraordinarily high standard of women capable of assisting in the building of a sturdy nation.

Heartburn

The most effective treatment of heartburn in pregnancy is the administration of cholinerges, of thiamine chloride and nicotinic acid, and dietary management. Reduction of the fat in the diet eliminating fried foods is frequently beneficial.

Anatomical Charts

The Anatomical Charts, prepared by Rudolf Schick Publishing Co., New York City, referred to in the review in the May, 1947, issue, are mounted on linen, with spring rollers, to give the charts a long life when much handled in schools of nursing.

AUX INFIRMIÈRES CANADIENNES-FRANÇAISES

Etude sur une Affiliation dans Sanatorium de Tuberculeux

LES infirmières ont encore à l'esprit les paroles du Dr. Vidal, président de la Commission de la lutte anti-tuberculeuse dans la province de Québec, paroles qu'il nous adressait lors de notre dernière assemblée annuelle. "Sans le concours des infirmières, la lutte contre la tuberculose est impossible," nous disait-il. Nous sommes donc en quelque sorte le gage du succès, en partie du moins, de cette lutte.

Ayant échangé à ce sujet des lettres avec Mlle Jeannette Loranger, infirmière du service de la Commission de la lutte anti-tuberculeuse, je me permets de publier quelques extraits de ces lettres et de soumettre à l'étude un plan pour une affiliation de deux mois dans un sanatorium de tuberculeux:

Si, comme vous le dites, le but proposé aux écoles d'infirmières par l'association est de permettre à l'infirmière, lorsqu'elle a terminé son cours, de donner des soins experts dans toutes les maladies, nous sommes loin, je crois, d'avoir atteint l'idéal pour ce qui concerne la tuberculose. Toutefois, nous avons fait du progrès, mais si notre taux de mortalité reste si élevé comparativement aux autres provinces, c'est que nous n'avons pas fait ici tout ce qui était humainement possible de faire. La preuve, voyez Ontario, qui en 1945 avait 25.8 décès par tuberculose par 100,000 de population, Saskatchewan 26.9, alors que Québec se permet de s'afficher avec 71.8 (2,557 décès). Ces chiffres sont éloquents et nous disent n'est-ce pas que nous avons encore quelque chose à faire?

Aussi, j'aimerais à enrôler le plus grand nombre d'infirmières possible dans la lutte que nous avons engagée contre cette maladie. A mon humble avis, il faudrait à tout prix que durant leur cours, les gardes-malades bénéficient d'un stage de deux à trois mois dans un hôpital spécialisé, comme celà se pratique en Ontario, en Saskatchewan, pour ne parler que de ces deux centres là. Ce qui s'est fait ailleurs peut se faire ici. Voici ce que pense l'Association des Infirmières de la Colombie-Britannique où le stage en T.B. est obligatoire pour toutes ses élèves infirmières.

Plusieurs sanatoria se plaignent de ne pouvoir avoir un personnel suffisant; les raisons données sont que l'on a peur de contracter la maladie ou que l'on n'a pas de connaissances spécifiques en tuberculose. L'Association des Infirmières de la Colombie-Britannique est d'avis que ces problèmes devraient être résolus durant le cours de l'élève infirmière, qu'un stage en tuberculose soit une partie de l'expérience que l'élève doit acquérir. Les problèmes précités seront résolus du fait même.

Comment veut-on que des infirmières diplômées, qui ne se sentent pas préparées et qui n'ont aucun encouragement à le faire, choisissent comme champ d'action le soin des tuberculeux.

Néanmoins, ce champ d'action, s'il est bien mis en valeur, stimule l'intérêt de l'infirmière, son habileté aux soins des malades et augmente ses connaissances. Par conséquent, nous croyons que le stage dans un sanatorium donnera des résultats et qu'il est aussi important que toutes les autres expériences au programme.

Il est aussi reconnu que chaque membre de la société a son rôle à jouer dans la lutte anti-

TABLEAU DES COURS ET DES ACTIVITES SCOLAIRES POUR UNE AFFILIATION DE HUIT SEMAINES DANS UN SANATORIUM DE TUBERCULEUX

Semaine de cours	*Cours*	*Démonstrations*	*Conférences*	*Activités scolaires*	*Devoirs*
I	1. Présentation et renseignements 2. Histoire de la tuberculose 3. Tuberculose pulmonaire A 4. Tuberculose pulmonaire B 5. Pathologie, anatomie et physiologie 6. Prélèvements (comment recueillir les) et technique de laboratoire 7. Service des repas	Technique aseptique, etc. Pneumothorax et thoracenthèse, (technique)	Conférence médicale	Visite de l'Institution	Dessins et explications de l'appareil à pneumothorax
II	1. Traitement général de la tuberculose pulmonaire	Observation d'une opération écrasement du nerf phrénique	Conférence médicale		Etude sur un sujet particulier
III	1. Prévention et contrôle de la tuberculose dans la Saskatchewan 2. Tuberculose osseuse et articulaire	Observation, inoculation, et post-mortem d'un cobaye			
IV	1. Traitement de la T.B. pulmonaire en chirurgie 2. Affection non pulmonaire état tuberculeux		Conférence médicale		Rapport écrit des observations faites en laboratoire
V	1. Observation des suites de la maladie (follow-up) 2. Récapitulation			Discussion en groupe sur la T.B. pulmonaire etc.	
VI	1. Epidémiologie et la vaccination par le B.C.G.	Epreuves à la tuberculine	Conférence médicale	Discussion en groupe sur la T.B. des os et des articulations	Etude d'un cas. Oral
VII	Orientation professionnelle et champ d'action			Discussion en groupe sur la T.B. de l'enfance	
VIII	Revue des questions de l'examen final				

Examens: 1ère semaine — Examen d'appréciation. 8e semaine — Examen final.

tuberculeuse. Un programme éducatif est nécessaire afin que chaque individu connaisse ses responsabilités envers la société.

Le succès d'un programme d'éducation dépend de l'activité, de l'intérêt et des qualifications d'un personnel bien entraîné. Les infirmières quelque soit leur champ d'action sont toutes indiquées pour enseigner les points importants de la prévention et du contrôle en T.B.

Mais ce n'est que par une affiliation que l'on peut faire réaliser aux infirmières l'étendu du problème tuberculeux et du fait stimuler leur intérêt et leur donner les connaissances nécessaires et les moyens d'y remédier. C'est la contribution qu'elles doivent apporter comme citoyenne de leur société et comme membre de leur profession.

Un programme très intéressant, venant de l'Association des Infirmières de la Saskatchewan, où ce projet a été mis à exécution avec beaucoup de succès, au Sanatorium de Fort Qu'Appelle, est publié ici.

Ces quelques feuilles doivent accompagner le tableau des diverses activités durant les huit semaines d'affiliation:

1. Buts du cours: De familiariser l'infirmière avec la tuberculose. La prédominance de la maladie. Les symptômes (et l'absence fréquents de symptômes). Le traitement subjectif. L'expérience pratique du traitement au sanatorium.

2. D'enseigner à l'étudiante infirmière que la tuberculose est contagieuse et faire ressortir la valeur de la prévention et du contrôle. Mesures protectives pour l'infirmière et pour les autres membres du personnel. Education du patient afin qu'il retire le maximum de bénéfice de son traitement et qu'il restreigne le danger d'être une occasion de péril pour la société. Occasions se présentant en hygiène publique. Adaptation psychologique nécessaire pour venir en contact avec les patients tuberculeux.

3. Afin d'enseigner à l'élève la nécessité de la réhabilitation et les moyens pour y parvenir.

Etat de santé et examen médical: Les étudiantes sont supposées venir au sanatorium en bonne santé. Toutes les étudiantes doivent avoir eu une réaction positive à la tuberculine ou avoir reçu du B.C.G. La vaccination doit avoir lieu lors de l'entrée de l'élève à sa propre école.

Au début du cours d'affiliation, chaque élève a une radiographie pulmonaire et un examen médical comprenant, analyse d'urine, et analyse du sang. En cas de maladie, l'élève est vue immédiatement par un médecin et l'école est avertie. Avant de quitter le sanatorium, chaque affiliée a une autre radiographie pulmonaire et un examen médical si on le juge à propos.

La visite de l'Institution: Par groupes, l'on conduit les affiliées dans les départements les plus importants, là où elles auront à aller durant les premiers jours. Après cette visite, chaque étudiante est conduite dans la salle où elle doit travailler et présenter à l'hospitalière. L'hospitalière aide à orienter la nouvelle venue en lui donnant des détails sur la salle, en lui présentant les autres membres du personnel et les patients dont elle prendra soin.

Les cours théoriques: Ils sont donnés durant la première semaine du stage hospitalier à raison de deux par jour, afin de donner aussitôt que possible une base au travail pratique. De cette façon, l'adaptation au milieu est beaucoup plus facile pour l'étudiante et celà lui permet dès le début de se protéger et de protéger les autres des dangers de l'infection et en plus celà lui permet de donner des meilleurs soins aux patients.

Les conférences médicales sont consacrées à la tuberculose pulmonaire parce que c'est la forme qui prédomine. En autant que la chose est possible, des cas illustrant le sujet discuté sont choisis parmi les patients du sanatorium et présentés lors de ces conférences.

L'un des cours est donné en partie sur la vaccination par le B.C.G., sa valeur, et son emploi chez l'infirmière étudiante sont soulignés. La diététicienne discute de la nutrition en tuberculose et décrit le service alimentaire de l'institution.

Les cours sur la prévention, la surveillance des malades sortis du sanatorium (follow-up) sont donnés par les personnes en charge des départements intéressés. La directrice des infirmières parle aux étudiantes de

l'attitude professionnelle et de l'orientation pour la future infirmière diplômée.

Démonstrations: L'on fait un pneumothorax et une thoracentèse devant un groupe. Chaque étudiante a l'occasion d'assister pour ces mêmes opérations durant la semaine qu'elle passe à la salle d'opération. L'on permet à l'étudiante d'observer toute opération chirurgicale importante. Au laboratoire l'étudiante observe les inoculations aux cobayes et est présente lors du post-mortem.

Devoirs: Une histoire de cas est préparée par chaque étudiante et présentée oralement à l'institutrice. L'importance de l'éducation du patient est souligné.

Conférences médicales: Les étudiantes ont la permission d'assister chaque semaine à la conférence du personnel médical. Les médecins présentent des cas nouveaux pour diagnostiser et discutent le cas de patients du sanatorium, de leurs progrès, de traitements nouveaux, ou de leur congé. Les élèves voient la valeur de ces conférences, elles écoutent les opinions de tous et la décision prise.

Occasion spéciale d'éducation: Lorsque quelque chose de spécial se présente, l'on en fait bénéficier les élèves.

Examens: L'examen d'appréciation au début du cours a pour but de se rendre compte des connaissances de l'élève en anatomie, physiologie, bactériologie, etc., se rapportant à l'étude de la tuberculose. Celà permet à l'élève de revoir une partie de ces matières qu'elle a pu oublier.

L'examen final est du type objectif. Les questions sont revues le lendemain de l'examen, les corrections sont faites, et tout ce qui n'est pas clair est expliqué de nouveau.

Rapport à l'école: Un rapport complet sur la théorie et la compétence qu'a l'élève est préparé par l'hospitalière de la salle où l'infirmière a travaillé. A la fin de son stage dans la salle, l'hospitalière a un dernier entretien avec l'élève, elle lui remet son rapport, l'élève le lit et le signe.

Cette évaluation est faite selon "Study Guide on Evaluation" de R. Louise McManus, National League of Nursing Education. Nombre total de points, 200; étude sur un sujet particulier, 15 à 30 points; histoire de cas, 10 à 20 points; examen final, 75 à 150 points. Le pourcentage est calculé en divisant le total par deux.

Nurse Instructors Hold Institute

Following the annual meeting of the Saskatchewan Registered Nurses' Association, for the third time a one-day institute for instructors in schools of nursing was held at the Hotel Saskatchewan, Regina. Noreen Lambert, instructor at the Holy Family Hospital, Prince Albert, and the retiring chairman of the Hospital and School of Nursing Section, presided, and K. Probert, instructor, Regina Grey Nuns' Hospital, acted as secretary.

Those attending were: Rev. Sr. Loretta, St. Elizabeth's Hospital, Humboldt; L. Garland, A. Aldridge, M. Palmer, and E. Hennigar, Regina General Hospital; C. Crowe, Fort San; M. Richardson, Saskatchewan Hospital, North Battleford; V. Parker, Victoria Hospital, Prince Albert; C. Lennie, J. Salte, and B. Fisher, Moose Jaw General Hospital; J. Hodsdon, P. Graham, E. Jefferson, and Y. Nishamura, Regina Grey Nuns' Hospital; Rev. Sr. Mandin, F. McDonald, E. Worobetz, M. Robinson, and S. Leeper, St. Paul's Hospital, Saskatoon; L. Willis, Saskatoon City Hospital; E. James, Yorkton General Hospital; Rev. Sr. Loretto, Holy Family Hospital, Prince Albert; Mrs. Naomi Koshnysh and H. Rutherford, Providence Hospital, Moose Jaw; K. W. Ellis, University of Saskatchewan School of Nursing; C. E. Jackson, travelling instructor, S.R.N.A.

Discussion centred around the teaching programs in schools of nursing; preparation for the First-Year Qualifying Examinations, which are to be held in Saskatchewan for the first time this year; the importance of clinical teaching and the special functions of clinical instructors. Course outlines for guidance in schools of nursing in Saskatchewan were also reviewed, and rating scales. A number of recommendations were prepared for the consideration of those responsible for the administration of schools and the S.R.N.A.

Notes from National Office

Exchange of Nurses Committee

ACTION was authorized by the above committee along the following lines: (1) approach to the appropriate governmental authorities; (2) obtaining legal counsel; (3) limitation of exchange privileges; (4) selection of candidates; (5) selection of initial practice fields and the appointment of a sub-committee to explore them; (6) extension of exchange privileges to Canadian nurses who wish to go abroad.

The general secretary visited Ottawa and was accorded a sympathetic hearing by officials of the Department of External Affairs and the Department of Immigration. These officials seemed interested in the project and saw no reason why it should not succeed, provided due care is taken to make certain that all regulations are scrupulously observed. Legal counsel was sought and steps are now being taken to draw up a suitable contract which will protect the interests of all concerned. It was agreed that exchange privileges would be granted to such persons as are able and willing to fulfil the conditions outlined by the Exchange of Nurses Committee and endorsed by the Canadian Nurses' Association. Tentative general principles, which should govern the selection of candidates, have been outlined and will be modified and expanded in the light of future experience. It was agreed that, at the outset, it would be wise to assign candidates to the Montreal area in order that they might be closely in touch with the National Office of the C.N.A., through which arrangements for their entry to Canada will officially be made. It is understood that practice areas in other parts of the country will be developed rapidly in the light of the initial experience thus obtained.

A sub-committee of Montreal members was appointed to explore the area in question. Considerable spadework has already been accomplished by this sub-committee and the response of both the English and French hospitals has been quite encouraging. The sub-committee is now engaged in formulating tentative programs of experience and in drawing up schedules for salary and maintenance which will be acceptable to all concerned. It was agreed that the primary aim of the Exchange of Nurses Committee is to provide exchange privileges for Canadian nurses in as full a measure as for nurses abroad. It was admitted, however, that this aim is greatly complicated by the severe conditions prevailing in Great Britain and on the continent. It was decided that the chairman and the secretary of the Exchange of Nurses Committee should jointly seek advice from various official agencies such as the Royal College of Nursing and the British National Nursing Council concerning the admission of a few carefully selected Canadian nurses who would adjust satisfactorily without adding to the burden of the directors of the institution in which they are received.

Joint Committee—Canadian Hospital Council and C.N.A.

At a meeting of the above committee, discussion centred around the following topics: (1) nursing service in hospitals and the reasons for shortage of staff; (2) nursing education and the need of a time-study and cost analysis; (3) personnel policies; (4) the need for informing the public and the medical profession in regard to the above points; (5) the control of

admissions in hospitals. The following recommendations were approved:

That the offer of the Canadian Medical Association to undertake a campaign of education of their members be heartily endorsed and accepted.

That hospital salaries be brought into line with the standard practice for comparable work and preparation in the centres concerned.

That hours of duty and pensions should conform to a similar standard practice.

That the principle of the 48-hour week be supported with preferably a 44-hour week when personnel permits.

That all groups of persons providing nursing care for gain should be placed under licensure in every province.

That the Joint Committee, through the Canadian Hospital Council, recommend to the provincial hospital associations that they ask their member hospitals to set up records and bookkeeping entries in accord with some accepted uniform pattern in order to make it possible to obtain data which will be of use in ascertaining the real cost of nursing education and of nursing care and service.

That the Joint Committee endeavor to obtain the funds necessary for a proper investigation of the serious situation existing in regard to nursing and that, as the problem is a national one, the first approach be made to the Department of National Health and Welfare.

That the question of admission to hospitals be left to a sub-committee of the Canadian Medical Association and the Canadian Hospital Council and the following suggestions passed on to the sub-committee: The need for more convalescent homes to be stressed, a greater use of clinics for treatment and diagnosis, and that internes should be taught not to order unnecessary treatments.

Following this meeting a brief, asking for a grant of money to enable us to conduct a scientific job analysis and cost study of nursing and nursing education, was prepared and presented to the Minister of Health and Welfare. The Minister received the delegation and gave generously of his time and attention and offered to make any suitable personnel from his department available for the study. No promise of financial help was received and we were advised to seek such help from the provincial departments of health as both education and public health come under the jurisdiction of the provinces.

When the committee again met it was decided to (a) ascertain the possibilities of receiving financial assistance to carry out the proposed study and (b) arrange for an interview with an expert from the International Health Division of the Rockefeller Foundation who could give advice as to the best method of conducting such a survey.

The question of hospitals throughout the country undertaking to train nurses' aides, as urged in a letter from the American College of Surgeons, was brought up and it was recommended that an article opposing such a wide-open policy should be published in *The Canadian Hospital* for the information of all hospitals.

British Nurses Relief Fund

The following contributions have been received from:

Children's Memorial Hospital, Montreal $15.00.

Alumnae Association, Homoeopathic Hospital, Montreal $15.00.

Manitoba Association of Registered Nurses $5.00.

Alberta Association of Registered Nurses $141.00.

Visits

The general secretary gave an address and took part in discussions at the meeting of the Maritime Hospital Association at St. Andrews, N.B., June 4-6, choosing as her topic "The Present Situation in Nursing." General emphasis was, however, placed on the importance of sound personnel policies and practices by employers of nurses.

The general secretary attended and took an active part in the Institute for Registry Personnel, held at the Royal Connaught Hotel, Hamilton, Ont., June 9-11. This institute was organized and convened by Miss M. Baker, registry adviser, Registered Nurses Association of Ontario. Two sessions, directed by the general secretary, were devoted to the discussion

of the all-important and timely subject of Public Relations.

Letter of Appreciation

Amsterdam, June 10, 1947.

To the Canadian Nurses' Association:

Now that we are again in Holland, all comes back to us quite vividly. How very much we enjoyed our most interesting trip to the U.S.! You can't half know how many fine impressions we have carried home with us. The financial help given to us makes us very grateful to you, for we could not otherwise have managed to come. Things are still so hopelessly involved that, but for your generosity, we should never have left Europe.

Our stay in the U.S. has meant very much to us, not only because of what we saw and what we got, but also of the personal contacts we had, and which we thoroughly enjoyed. It stimulates us to take up our tasks again in Europe, where everything is so quite different and circumstances are so hard to tackle. So, also on behalf of our delegates, I thank you most heartily for all you did for us.

We all hope that the future may bring us together again. Whenever one of you should come to Holland, please let us know. We should be so happy to have you here.

With kindest regards,

Yours sincerely,

C. H. Menalda, President.

Notes du Secrétariat de l'A.I.C.

Le Comite d'Echange d'Infirmieres

Le comité prit les décisions suivantes concernant les possibilités d'échanger des infirmières des pays d'Europe contre des infirmières canadiennes: (1) avoir une entrevue avec le gouvernement; (2) obtenir l'opinion de notre aviseur légal; (3) restrictions apportées aux échanges; (4) choix des candidates; (5) choix des lieux de l'expérience et la nomination d'un souscomité pour étudier cette question; (6) que le même privilège soit offert aux infirmières désireuses d'aller outremer.

La secrétaire général alla à Ottawa et eut une entrevue avec les autorités du Département des Affaires Extérieures et du Ministère de l'Immigration. Les autorités virent ce projet d'un oeil favorable et ne voient aucun obstacle à son succès pourvu que l'on observe avec soins scrupuleux tous les règlements.

L'aviseur légal est à préparer un contrat pour protéger les intérêts de tous.

Il fut décidé que seules les infirmières pouvant remplir les conditions émises par le comité d'échange d'infirmières pourront bénéficier de l'échange. Quelques principes généraux, qui seront modifiés à la suite des premières expériences, ont été tracés.

Il a été décidé, qu'il serait sage, du moins au début, que les candidates soient placées à Montréal, afin qu'elles soient près du secrétariat national, lequel fera les démarches officielles pour l'obtention de leur entrée au Canada. Il est bien entendu que plus tard d'autres centres seront ouverts. Les hôpitaux de langue française et de langue anglaise ont accueilli ce projet très favorablement. Actuellement le sous-comité prépare un programme, une échelle de salaires, et détermine les conditions de travail qui seront convenables pour tous.

A cause des conditions actuelles difficiles en Europe, l'envoie d'infirmières canadiennes est très compliqué et il a été décidé, qu'avant d'envoyer une infirmière canadienne, qu'une sérieuse étude sera faite, afin de se rendre compte qu'elle ne sera pas à charge.

Le Comite Conjoint

Les questions suivantes furent discutées lors de l'assemblée du comité du conseil des hôpitaux et de l'Association des Infirmières du Canada: (1) le service des infirmières et les causes de la pénurie d'infirmières; (2) la formation de l'infirmière, la nécessité d'étudier le temps nécessaire à cette formation et d'en analyser le coût; (3) politique à l'égard du personnel; (4) la nécessité de renseigner le public et les médecins sur les questions déjà mentionnées; (5) contrôle des admissions à l'hôpital.

Les recommandations suivantes furent faites; Que l'offre de la "Canadian Medical Association" soit acceptée, à savoir: Que

l'association entreprenne une campagne éducative parmi ses membres concernant les problèmes hospitaliers. Que les salaires dans les hôpitaux soient l'égal de ceux généralement payés en comparaison du travail et de la préparation des membres. Qu'il en soit de même pour les heures et les conditions de travail. Que l'on accepte le principe de la semaine de 48 heures mais de préférence de 44 heures lorsque le personnel est suffisant. Que toutes les personnes donnant des soins aux malades moyennant rémunérations aient une licence provinciale.

Le comité conjoint recommande, par l'entremise du Conseil des Hôpitaux, à toutes les associations provinciales d'hôpitaux d'adopter le même système de comptabilité et les mêmes formules, afin qu'il soit possible d'établir le coût réel de la formation de l'infirmière et le coût du soin aux malades. Et le comité demande l'aide du gouvernement fédéral pour faire ces analyses.

Que la question de l'admission des patients soit laissé aux soins du Conseil des Hôpitaux du Canada et au "Canadian Medical Association" et que les points suivants soient étudiés par un sous-comité: Le besoin d'un plus grand nombre d'hôpitaux de convalescents; que l'on se serve d'avantage des hôpitaux pour les besoins de diagnostic et de traitements; et que l'on enseigne aux internes de ne pas prescrire de traitements qui ne sont pas nécessaires.

Après l'assemblée, un résumé fut préparé et présenté au Ministre de la Santé et du Bien-Etre concernant l'obtention d'un octroi pour l'étude de la formation de l'infirmière et le coût de cette formation. Le ministre suggéra que cette requête soit présentée aux ministères provinciaux puisque la santé et l'éducation relèvent des provinces.

A la réunion suivante du comité, il fut décidé: (a) de s'assurer d'une aide financière pour conduire l'étude préposée; (b) qu'une entrevue soit demandée avec un expert de "International Health Division of the Rockefeller Foundation" afin d'avoir son avis sur la meilleure manière de conduire cette étude.

La question de former des aides dans les hôpitaux tel que demandé par "American College of Surgeons" a été présentée et il fut décidé qu'un article s'opposant à un plan aussi général soit publié dans *The Canadian Hospital.*

Visites

La secrétaire générale de l'A.I.C. adressa la parole lors de l'assemblée de l'Association des Hôpitaux des Provinces Maritimes à St-Andrews, N.B., le 4-6 juin. Elle parla de la situation actuelle du nursing.

Remerciements

Les infirmières de Hollande, de retour dans leur pays, remercient l'A.I.C. dont la générosité leur a permi d'assister au congrès international. Ce bref séjour en terre d'Amérique a été une inspiration, un stimulant, et un réconfort qui leur permettront de continuer leur travail même dans les conditions difficiles actuelles.

Annual Meeting in Alberta

The twenty-ninth annual meeting of the Alberta Association of Registered Nurses was held April 18-19, 1947, at the Palliser Hotel, Calgary, with the president, Miss Barbara A. Beattie, in the chair. One hundred and thirty-seven members, representing fifteen centres, registered. An address of welcome on behalf of the city of Calgary was given by the deputy mayor, Mr. F. R. Freeze. A telegram of good wishes and greetings from Miss Evelyn Mallory, president, R.N.A.B.C., was read.

In her presidential address, Miss Beattie mentioned the positions of significance that had been filled during the past year by Albertans and paid special tribute to Miss Rae Chittick, of Calgary, president of the Canadian Nurses' Association.

Educational Policy: Miss Helen E. Penhale reported the progress being made.

1. *Expansion of clinical facilities:* Subcommittees have drafted basic forms for use if and when tuberculosis sanatoria, mental hospitals, and selected rural hospitals are used as affiliation institutions for student nurses. Progress is being greatly delayed in starting these affiliations due to not having an adviser for schools of nursing in

Alberta. Greatest advance is being made in connection with the tuberculosis sanatorium at Calgary.

2. "*Regulations Governing Schools of Nursing in Alberta*," as issued by the University of Alberta. This pamphlet is being revised and will be available in the autumn of 1947.

3. *Central school of nursing:* This idea grew out of the resolutions sent by the C.N.A. following the biennial meeting in Toronto, July, 1946. The provincial committee, formed to deal with the resolutions, delegated the work of drafting material regarding a central school plan to the nurse representatives.

4. *Institute on tests and measurements:* In response to requests that assistance be given to instructors, supervisors, and head nurses in schools of nursing in connection with examination papers — modern trends, setting, evaluating, etc.—an institute was arranged to be held at the University of Alberta in June. Miss Helen E. Penhale, M.A., director of the School of Nursing, University of Alberta, and Rev. Sister Jeanne Forest, M.A., educational director, Holy Cross Hospital, Calgary, conducted the course which was sponsored by the A.A.R.N.

5. *A.A.R.N. Library:* The A.A.R.N. Library is housed with that of the School of Nursing, University of Alberta. During the year the books were catalogued and policies formulated. Publicity is planned by having information concerning the library on the revised annual membership cards.

HEALTH INSURANCE: Miss F. E. C. Reid reported that a brief had been submitted to the Department of Public Health.

LEGISLATION: Miss Margaret S. Fraser reported that this committee had been very active during the year in connection with (1) the C.N.A. Constitution and By-Laws; (2) the new minimum education requirements for admission to schools of nursing; (3) preparation of a second Digest to help secure happier, more contented nurses, better nursing service, and more business-like personnel policies between nurses and employers of nurses; (4) necessary amendments to the present A.A.R.N. By-Laws.

The chief By-Law amendments, approved by the general meeting, related to: (1) The personnel of the Council; (2) standing committees; (3) district and chapter associations; (4) increase of registration fee for reciprocal registrants from $7.00 to $10.00.

Minimum education requirements for admission to schools of nursing: Section 4 of the Registered Nurses' Act, 1941, was amended by the Alberta Legislature and assented to March 21, 1947. The new regulations state the minimum is not fewer than sixty-seven high school credits which shall include "B" standing or higher in the following subjects, viz.: English 1 and 2, one foreign language 1 and 2, algebra 1, geometry 1, physics 1 or biology 1, chemistry 1, health 1 and physical education 1, or has obtained in Alberta or elsewhere an equivalent educational standing. Until June 30, 1949, applications will be considered of students who meet the requirements of either the 1947 Amendment *or* the 1941 Registered Nurses' Act.

LABOR RELATIONS: Miss Barbara A. Beattie made reference to the following: (1) that the "*principle* of superannuation" was generally accepted for Alberta hospitals at the convention of the Associated Hospitals of Alberta held in November, 1946; (2) that the salaries for graduate nurses are well above the minimum proposed by the A.A.R.N. in 1945; (3) that the staff situation in hospitals has improved, both from the standpoint of numbers and stability; (4) that more subsidiary workers are being employed in hospitals; (5) that more hospitals have adopted the 48-hour week.

Partly in response to a resolution passed at the general meeting, 1946, a Digest was prepared by the Labor Relations and Legislation Committees to help nurses and nurse employers. The Digest was discussed at the meeting and it was decided to request the advice and co-operation of the Associated Hospitals of Alberta. The Digest is not yet ready for general distribution.

NURSE PLACEMENT SERVICE: Miss Margaret Cogswell reported that since the Nurse Placement Service was instituted in September, 1945, she had visited 82 of Alberta's 104 hospitals. Since April, 1947, N.P.S. has been operated in conjunction with National Employment Service. Nurses' salaries, generally speaking, have been raised considerably during the year. A fairly average salary for general duty nurses in small hospitals is $110 per month in addition to maintenance.

REVISION OF THE ALBERTA REGISTERED NURSES' ACT AND BY-LAWS: Miss Madeline McCulla spent considerable time in outlining the revisions that had been made. Discussion took place following which it was

decided that the Nurse Practice Act Committee should do further work and present a report at the general meeting, 1948.

SUBSIDIARY WORKERS: Miss Margaret S. Fraser reported that the A.A.R.N. was active on a committee appointed by the Minister of Health in 1946 to prepare a "Licensing Act for Nursing Aides." The Act was assented to March 21, 1947. The Advisory Committee, A.A.R.N., at the request of the Department of Health, prepared the curriculum for use in the C.V.T. School in Calgary for nursing aides. Miss Frances Ferguson, director of the school and registrar-consultant for nursing aides, gave an interesting description and report of the school.

FUNDS FOR NURSING PROJECTS: (1) *War Memorial Trust Fund:* Miss Margaret Thompson, chairman, explained the purpose and plan and urged that donations be made. (2) *Toward expenses of Dutch nurse-delegates to I.C.N. Congress:* $148 was donated. The quota was over-subscribed by $23. (3) *Rest-Break Homes and British Nurses Relief Fund:* The need was explained and the plan discussed; $141 has been donated to date.

DISTRICT REPORTS were given by representatives. The nurses of Medicine Hat District (approximately 45 in number) received special acclaim and tribute for the raising of $1,032.57 during the past year.

HOSPITAL AND SCHOOL OF NURSING: Miss Anne Anderson reported on the assistance given with the revision of the A.A.R.N. By-Laws; formulating of requirements for rural hospital affiliations; arrangements for an article on personnel policies to be printed in *The Canadian Nurse.*

GENERAL NURSING: Mrs. Bertha Kipp gave an outline of the changes effected in fee schedules for private duty nurses in Lethbridge, Calgary, and Edmonton.

PUBLIC HEALTH: Miss E. Irene Stewart gave an account of the meetings of the year.

The above three sections in the A.A.R.N. were discontinued in accordance with the C.N.A. policy and replaced by: (1) the Committee on Institutional Nursing; (2) the Committee on Private Duty Nursing; (3) the Committee on Public Health Nursing.

The guest speakers were Dr. Charlotte Whitton, C.B.E., Ottawa, and Dr. E. P. Scarlett, Calgary. Miss Rae Chittick, president of the Canadian Nurses' Association, discussed various major activities of the C.N.A.

E. BELL ROGERS
Registrar, A.A.R.N.

Annual Meeting in British Columbia

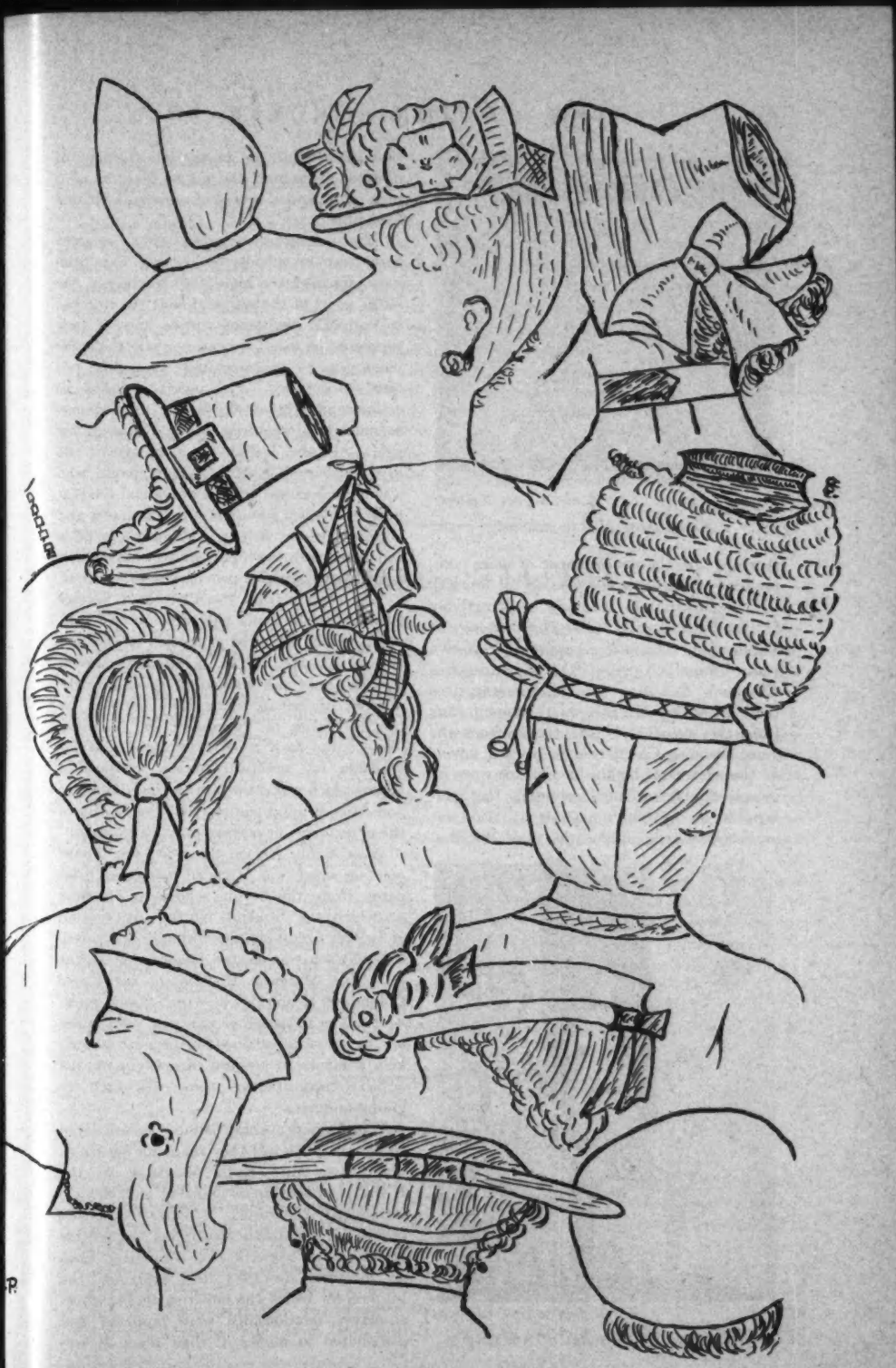
Two hundred and thirty-six nurses, representing thirty-six communities, registered for the day sessions at the annual meeting of the Registered Nurses' Association of British Columbia held at St. Paul's Hospital, Vancouver, on April 11-12, 1947. The attendance Friday evening at Shaughnessy Hospital was well over three hundred.

Miss Evelyn Mallory presided at all sessions. In her presidential address she reviewed the objectives and some of the changes accomplished in the revision of the C.N.A. Constitution and By-Laws; the plans for a demonstration of an independent school of nursing; and the organization and objectives of the Joint Planning Committee on Nursing. She also reviewed the functions of districts and chapters and urged delegates "to take back to their respective groups our plea for more active participation in professional affairs."

D'Arcy Studios, Vancouver
Convention exhibit

The reports from the seven districts showed that the chapters and districts are holding regular meetings with varied programs, are taking an active part in civic affairs, and are ably representing and interpreting nursing in their respective communities.

Miss Paulson's report on Health Insurance and Nursing Service emphasized that the solution of problems of nursing service



What nurses wear at conventions

D'Arcy Studios, Vancouver

Canadian Nurse exhibit

shortage and the development of more comprehensive curricula in schools of nursing are fundamental in planning constructively for health insurance. The convener of the Publications Committee reported an active year. The exhibit prepared by the Vancouver Chapter's *Canadian Nurse* representatives drew attention to the many contributors from this province. The report from the Joint Planning Committee on Nursing covered the work done by this committee since its inception last summer, including the findings of an activity analysis carried out in hospitals, the preparation and distribution of a guide for on-the-job training of hospital aides, and the major features of a plan for a central school of nursing in British Columbia.

Don McLeod, Vancouver

Illustrating branches of nursing

The registrar reported that student enrolment in schools of nursing has been maintained at the high level reached in the latter years of the war and that the number of currently registered nurses and of new registered nurses increased over the previous year by approximately 9.5 and 28 per cent respectively. Her report included an estimate of present shortage of nursing personnel and of requirements in the next few years. It also included a summary of the brief submitted to Mr. Graham Davis, who was commissioned by the provincial government to make a survey of hospital needs, and outlined briefly British Columbia's policies connected with the registration of nurses who come to us from other provinces and countries.

The reports from the Placement Service Committee and from the director of Placement Service reviewed expansion of this service as indicated by an increased enrolment for placement and a startling increase in the number of private duty calls handled by the directories in Vancouver and Victoria. The committee's report contained the fee schedule for practical nurses working in homes which was drawn up by the committee and Miss Braund summarized the results of the experiment in placing practical nurses.

Miss Emily Nelson described the dinner meeting which was attended by student delegates from the seven schools of nursing at which the Student Nurses' Association of British Columbia was formally organized. Miss Nelson was elected honorary president and Miss Margaret Roddan, of the Royal Columbian Hospital School of Nursing, president. The purposes of this new association are to promote professional interest and to help students to prepare themselves for the added responsibilities they will face as graduate nurses.

The Friday evening session was devoted to various phases of the "economic security" program. Miss Ruth Morrison, of the U.B.C. Department of Nursing and Health, introduced the topic. Miss Copeland's report on the Labor Relations Committee reviewed the work of this committee since its inception in 1943 and explained the purpose for which the bulletins on employer-employee relationships were prepared and distributed to nurses at their place of em-

ployment. Reference was made to the C.N.A. memorandum on unemployment insurance and to the committee study of this subject. The registrar reported on the Select Committee on Labor Relations. The work of this committee is in its infancy but the fact that seven employee groups of nurses had elected members of this committee to act on their behalf as certified bargaining representatives indicates that nurses are turning to their professional association for assistance in solving their economic and other problems. The report on the 1947 R.N.A.B.C. personnel practices evoked much discussion.

Miss Creasor, convener of the Legislation Committee, presented the proposed amendments to the Constitution and By-Laws. They were voted on and approved with one additional amendment — the committees on Labor Relations and Health Insurance were made standing committees.

The attendance at the luncheon was 148 and Mrs. Rex Eaton, in her address on "Women in World Affairs," told of the International Assembly of Women which met in New York last fall. The St. Paul's Hospital Alumnae Association was hostess at a delightful tea which came at the end of two days of strenuous meetings.

ALICE L. WRIGHT
Executive Secretary, R.N.A.B.C.

Annual Meeting in Manitoba

The thirty-third annual meeting of the Manitoba Association of Registered Nurses was held April 21-22, 1947, at the Fort Garry Hotel, Winnipeg. The meeting opened with the Public Health luncheon at noon, April 21. The address of welcome was given by His Worship, Mayor Coulter, and the guest speaker was Dr. E. F. Willoughby, principal of Kelvin Technical High School. His address, "Ramparts of Peace," dealt with UNESCO and the meeting at Paris where he was delegate from Canada. At the afternoon session reports were heard from the president, executive secretary, president of the Manitoba Student Nurses' Association, and the graduate nurses' associations. In the evening the speaker was Mr. T. W. Laidlaw, K.C., who was introduced by the Hon. C. Rhodes Smith, Minister of Labor. Mr. Laidlaw's address was entitled "Collective Bargaining" and was most timely and informative. He answered many questions which arose during the discussion period.

Tuesday morning was given over to reports from the sections, standing and special committees, and representatives. The two speakers during the afternoon were Miss Alice Smith, Cancer Institute, and Dr. E. L. Ross, medical director, Manitoba Sanatorium Board, their respective topics being "Cancer" and "Tuberculosis." The climax to a successful annual meeting was the banquet held Tuesday night with a record attendance. Dr. Athol Gordon was the guest speaker, choosing as his topic "The Nurse in this Changing Age."

LAURA B. FAIR
Executive Secretary, M.A.R.N.

Annual Meeting in Ontario

The twenty-second annual meeting of the Registered Nurses Association of Ontario was held at the Royal Connaught Hotel, Hamilton, on April 23-25, 1947. Following the opening of the meeting by the president, Miss N. D. Fidler, a welcome from the City of Hamilton was extended by Mayor Lawrence, and from the district by the chairman, Miss Anna M. Oram. We were pleased to have with us Miss Margaret E. Kerr, editor and business manager of *The Canadian Nurse*, who brought greetings from the National Office and also expressed her appreciation of the opportunity to attend the annual meeting and meet with members from all parts of Ontario. A message from

Miss Rae Chittick, president, Canadian Nurses' Association, was read by the chairman.

The president, Miss N. D. Fidler, presided at all business sessions. A folio of the reports was prepared in the provincial office and distributed to all who registered. This plan made it possible for the delegates to follow the reports as presented for discussion and the folio will be of assistance to them when writing up their report of the meeting. The registration for the full meeting was 415 with an additional number of 394 who attended one or more sessions.

One of the important questions for discussion on the first day was the presentation of the proposed draft of a Nurse Practice Bill by the convener of the Legislation Committee, Miss Mary B. Millman. The proposed draft was in two parts to include both the professional nurses and the nursing assistants. The proposed draft was fully discussed, point by point, on the first day and, for the benefit of those who were unable to attend, a summary was presented by the convener on the second day, when an opportunity for further discussion was provided. The decision as to whether a bill embodying the principles outlined in the proposed draft should be prepared was made in a ballot vote. The result of the voting indicated that a large majority were in favor of a bill and, following the presentation of this report, authority to proceed with the preparation of a bill was granted.

The Hospital and School of Nursing and the Public Health sections held their business meetings concurrently on the morning of April 24. The arrangement made in 1946, that the General Nursing section hold their business meeting at 5 p.m., was again followed this year, as it was the opinion that many more private duty nurses were able to attend at the later hour.

A panel discussion on "Nursing as a Community Service" was conducted under the able chairmanship of Miss Edna L. Moore. Those who assisted with the panel were keenly interested in the topic and discussed the following points: "The Community"— Prof. C. W. M. Hart, M.A., associate professor and supervisor of studies in Sociology, University of Toronto; "Community Needs" — Mr. James Dutton; "The Legislator and Nursing"— Dr. R. Hobbs-Taylor, M.D., M.L.A., provincial member for Huron constituency; "Problems in Meeting Community Needs"— Miss Helen M. Carpenter, M.P.H., director of nursing service, East York-Leaside Health Unit, and Miss Lucy M. Ashton, health supervisor, Hospital for Sick Children. The interest of the delegates in this session was demonstrated by an attendance of approximately six hundred.

On Thursday evening, April 24, 460 attended the annual dinner when Miss Nora Frances Henderson, controller for the City of Hamilton, spoke on "The Place of Women in Democracy." In her address Miss Henderson pointed out the authority which women could exert, both as individuals and as groups, encouraging them to take a constant and practical interest in the affairs of their communities and their country.

The association appreciated the support and co-operation of the twelve commercial firms whose exhibits were of great interest to the delegates and added much to the success of the meeting.

The 1948 meeting will be held in Toronto on April 22-24.

MATILDA E. FITZGERALD
Secretary-Treasurer, R.N.A.O.

Annual Meeting in Saskatchewan

On May 29-30, 1947, the thirtieth annual meeting of the Registered Nurses' Association was held in Regina. There was an attendance of approximately two hundred nurses, representing twenty-seven different centres in the province, and seven visitors from outside of Saskatchewan including one from New York. Student nurses from nine different schools in the province were welcomed to the meeting. The response to the address of welcome was given by a charter member of the association, Mrs. W. M. Van Valkenburg, of Regina. Messages of greeting were received with applause from two other charter members: Miss Jean S. Wilson, Almonte, Ont. and Mrs. F. E. Feeny, Dearborn, Mich. The

morning session of the first day was devoted to business and meetings of three sections, in future to be standing committees.

In the afternoon Dr. H. Bucove, medical health officer, and Mrs. H. Fletcher, senior public health nurse, Health Region No. 3, gave a most enlightening presentation on "Public Health in the Health Regions." At this session members learned in detail just what is being done for the people in these regions. A delightful tea, at which the Regina and Moose Jaw Chapters were joint hostesses, followed the conclusion of the afternoon meeting. Misses Mary Brown and C. Lennie, recently elected presidents of the respective chapters, received the guests.

On Friday, special reports were presented and discussed. An innovation at the meeting was the presentation of reports from chapters. They contained many varied and interesting items such as: Parcels for nurses in Holland and Great Britain, a responsibility which has been readily assumed by chapters; contribution for Rest-Break Homes in Great Britain and assistance in bringing a delegate from Holland to the I.C.N. Congress; gifts of welcome to members of graduating classes; support of community "drives"; the establishment of a Cod Liver Oil Fund for children — in one centre 287 children have already benefitted from this; representation from the chapters on the Central Council and School Clubs, the Film Council, etc.; assistance and furnishings to local hospitals; assistance to a crippled girl and other individuals in need. It was interesting to note that a great deal of assistance comes from the associate members, who are the so-called "inactive" (married) nurses in the community.

A film and short address on "Saskatchewan Seasons," by Fred Bard, director, Provincial Museum, brought a most fascinating glimpse of flowers and animal life in this prairie province. A presentation by student nurses, under the guidance of Miss Lucy Willis, was one of the most popular contributions on the program. During this panel discussion, four aspects of a nurse's development during the course were presented — the spiritual, social, physical, and mental. Members also heard of the experiences of "Disastrous Daisy" and "Superior Susan," which portrayed in a brief sketch the reaction of these two students to their experiences as student nurses. Miss Jean Hodsdon and her committee took charge of arrangements which added so much to the success of the convention. One of the highlights was the exhibit prepared by students in schools of nursing. Miss Noreen Lambert and Miss Marguerite Palmer were in charge of arrangements.

K. W. Ellis
Registrar, S.R.N.A.

Victorian Order of Nurses for Canada

In more ways than one, the forty-ninth annual meeting of the Victorian Order of Nurses for Canada was the most successful in the history of the Order. There were 291 delegates registered from 86 branches, an all-time high, and they came from as far west as Victoria, B.C., and as far east as Halifax, N.S. It was the final annual meeting for Miss Elizabeth Smellie, climaxing her outstanding career of twenty-three years as chief superintendent, and the highest tribute was paid to her by Her Excellency, Lady Alexander, Mr. Leonard W. Brockington, K.C., LL.D., Prime Minister W. L. Mackenzie King, who sent his tribute through the Honorable Paul Martin, Minister of National Health and Welfare, the Executive Council, members of local boards, and the Victorian Order nurses. Everyone was sad to say farewell to Miss Smellie, but the sadness was overcome to some extent by the pleasure of hearing the announcement that Miss Maude H. Hall, who has been assistant superintendent for so many years, has been appointed the new chief superintendent. Her appointment has the whole-hearted approval of the many people who have had occasion to know her wisdom and her capable administration in the past.

One of the outstanding features was the presence, for the first time, of the general superintendent of the Queen's Institute of District Nursing, Miss E. M. Crothers, who brought greetings from the Earl of Athlone

and from the Victorian Order's "elder sisters" in Great Britain, the Queen's nurses. Miss Crothers also told the delegates something of the work of the Queen's Institute and gave praise for the work of the Victorian Order. In speaking of the shortage of nurses which is perhaps even more acute in Britain than in Canada, she said that every effort is being made to provide cars so as to make the most efficient use of the limited staff. "I am glad to see that more and more of your nurses are getting cars," she said. "I think that a nurse is far too valuable and precious a possession to have her trudging down side streets or waiting for street-cars."

The guest speakers at the various sessions included the Honorable Paul Martin, Minister of National Health and Welfare, Dr. Edward Hall, Dean of Medicine and President-elect of the University of Western Ontario, and Mr. L. Brockington, K.C., LL.D.

For the first time since before the war, the entire second day was devoted to general discussion of a number of mutual problems such as: the relationship between the board of management and the nurse; meeting increasing demands on restricted budgets; the establishment of an Educational Fund; salary schedules; uniform allowance, and so on. The discussion was lively. It served to show that there are problems that are similar in many branches and many helpful suggestions were made.

Following the close of the meeting the president, the Honorable Norman Paterson, and Mrs. Paterson entertained the delegates and the nurses at tea at their residence.

An interesting sidelight was the two enterprising delegates, from North Vancouver, B.C., who travelled across the better part of a continent to attend the meeting — and made it pay. Mrs. Chamberlain and Mrs. Johnson were the North Vancouver delegates. They bought an automobile in eastern Canada for their nurse, drove it home, and thereby saved the approximate $250 shipping charges.

National League of Nursing Education Convention

The National League of Nursing Education extends an invitation to Canadian nurses to attend the League's fifty-first annual convention in Seattle, Washington, from September 8-11, 1947. The headquarters will be the Olympic Hotel.

The League hopes the Canadian nurses can combine a trip to Seattle for the convention with their vacations. A very interesting program has been planned and many scenic local tours have been arranged by the sub-committee on Sightseeing and Transportation so that the visiting nurses will be able to see some of the beauties of the centre of the northwest. Miss Grace Watson, chairman of this sub-committee, whose address is Washington Public Health Department, Seattle, Wash., will supply information about local tours upon request. Any local railroad going direct to Seattle, or a connecting line, will be glad to arrange a sightseeing tour to and from the convention. If Canadian nurses have not made their vacation plans, we hope they will include the Seattle convention in their itinerary.

For hotel accommodations they should write at once to Miss Gertie Hyptmo, chairman of the sub-committee on Housing, 514 Medical Arts Bldg., Seattle 1, Wash. Single rooms are very limited and arrangements should be made to share a twin-bedded room with a friend. The registration fee will be $4.50 for members and guests and $2.25 for student nurses.

Nursing Sisters' Association

At a meeting of the Executive Committee of the *Ottawa Unit* a report was received on the bridge and raffle held to raise money for the Rehabilitation Fund for nurses in the devastated countries which is being sponsored by the N.S.A.C. The proceeds, a cheque for $1000, has been forwarded to the National Association in Saint John.

The Unit recently entertained at tea at Trafalgar House, the Canadian Legion Headquarters, in honor of Miss Elizabeth Smellie, when a presentation was made.

STUDENT NURSES PAGE

My Out-Patient Experience

HELEN THOMAS

Student Nurse, School of Nursing, St. Michael's Hospital, Toronto

TO A STUDENT NURSE, the chief value of her week's observation in the Out-Patients' Clinic lies in her changed perspective of the ward patient. In the wards, we see a patient, lying in fresh linens, comfortable, clean, being given the best of medical care and nursing service. But do we think of the home our patient has come from or of the home to which she will sooner or later return? Her routine in hospital is not ordinary—it is "extra-ordinary." Do we often forget this and, therefore, neglect to explain and teach prophylaxis and personal hygiene, and other things which seem trivialities to us, but to our patient are mountains? I think the visit of the student to the patients' homes with the St. Elizabeth nurse is a very valuable experience. Never again will I become the least bit impatient with those poor souls on the public wards, so vividly have I viewed their home conditions. Let me tell you about one of the experiences I had on my afternoon of visiting.

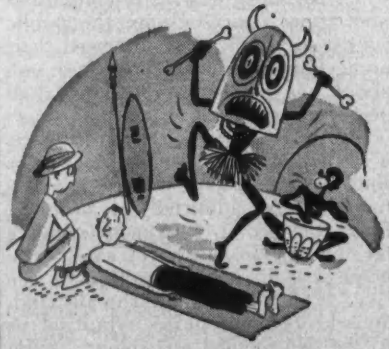
She was a new patient on Mrs. T's visiting list. All we knew was that she was a cardiac case, who refused to be admitted to hospital. Even the worst I expected was a far, far cry from what I saw. The home was in a poor section of the city. A shiftless Italian, the husband, housekeeper and nurse, admitted us to the two-roomed apartment. "You want to see old lady?" he asked in broken English. Then he pointed to a door and said, "In there." She was the remnants of a once hale, hearty, happy Italian "senora." Poor, pour soul! I wish I could tell you every detail so your heart could go out in pity and kindness to her. In that room I saw the hardships and unkindness of poverty, the trial of old age and its helplessness. I felt a great desire within me at that moment to be ever very kind and gentle and patient with every patient. (Nurses, realize this — "Be kind." Remember what the patient may have come from and what she will return to. Let us make her stay in hospital pleasant. Teach patients the elements of hygiene. One can hardly visualize home conditions that exist, until one has actually had close contact with the houses in "Poverty Row.") I stood there and wondered how long it had been since the poor old senora had had her bed made — and how I should have liked to wring those filthy sheets into white sheets! She possessed no other clean bedding; no gown other than the one on her and that was ragged and dirty. To keep her warm, she had her husband's threadbare winter overcoat thrown over the bed. The room was chilly and damp. On entering, the woman received us fearfully and distrustingly. She was frightened, but the gentle manner of the St. Elizabeth visiting nurse soon won her confidence although she remained reticent all during our visit. She could speak only a word or two of English and neither she nor her husband could write. The old lady soon became grateful for our visit.

Curb Service. Dr. Chauncey Everitt was knocked down by a Newark, N.J. motorist. The obliging driver got out, moved Dr. Everitt off the road and drove away.

Parting Shot. Howard C. Gebhart was left $1 in the will of his divorced wife's estate for bullets. The late Mrs. Gebhart had written, "I hope he shoots himself with one."

Attention Management. Hire a man with duodenal ulcer is Dr. Charles W. Mayo's advice when looking for a hard worker. The famous medico says an ulcer makes people high-strung and drives them to better work.

The power of advertising. Port Alberni, B.C. is the locale, and it really happened. An owner of a riding horse advertised the fact that his mount was missing. The next day the horse, bridle and all, turned up at the newspaper office. A shaken editor took charge.



"He says he got his degree at Arthur Murray."

The old man was complaining that his "old woman was too old." (Too old to live! Do we ever think that too, nurses? That's what the Nazis said—"Too old to live" and so they justified the "mercy killings." Let us be thankful that in Canada we still have "Mercy Hospital," not mercy killing. Perhaps I have diverged far from the topic but, to me, what I have just written has been my most valuable experience.)

The experience in the Out-Patients' Clinic helps the student nurse to acquire an understanding of the individual in the community, his health and social needs, and the available resources for the betterment of each. To any city, a clinic is one of its most valuable resources. It is here that the very poor come and they are given free medical care; here, too, comes the young expectant mother. To our clinic, are sent those in need of medical care in the House of Industry and the House of Providence. To the social and health services come the patients faced with difficulties and problems. A mention of but a few of these will suffice to show of what importance the settling of them is to the health and well-being of these individuals:

1. Carfare for transportation from outlying parts of the city to clinic.
2. Money to obtain glasses, dentures, or even artificial limbs.
3. Money for special diet foods advised by a doctor.
4. The hopelessness of the young unmarried mother, who knows not where to turn in her hour of difficulty.
5. The need of the aged, homeless man and woman.

Yes, the social service workers are asked to work miracles, and I saw them doing it.

The knowledge and skill necessary for bedside nursing is concretely shown to the nurse during her experience here. After the patient has received the doctor's orders we must see that she understands them and knows how to carry them out. The problem may be teaching the use of insulin; instruction of the tuberculous patient in the care of himself, and protection of his family and friends; teaching the ways of preventing the spread of venereal diseases.

The "follow-up" work done in the clinics by the health service is excellent. To our chest clinic any patient can come regardless of his financial position. If the findings are negative, the patient is relieved of his fear and apprehension. The contacts of those found positive are located and requested to come to clinic for examination. Thus the spread of tuberculosis is being arrested. A close follow-up is carried out in our special clinic — if a man or woman fails to report after two warnings, a district nurse may be asked to call at the home. In all clinics one meets and observes not only future patients, but also those not requiring hospitalization.

Here one learns to recognize the problems arising out of hospitalization, particularly during our visits to the wards with the health service nurse. For the patient anxious about her children, left uncared for, the health nurse arranges for their placement in boarding homes, or the services of a visiting home mother. How these patients confide in and rely on the health service nurse! I watched them as they told their troubles to her, and I marvelled at how broad and strong her shoulders must be to share and solve the problems of so many.

By no means the least important is the link between patient and hospital before and after admission — for example, the postnatal and prenatal clinics. Regular attendance at prenatal clinics ensures the expectant mother of the necessary medical attention by which any complications may be detected and treated. As well, the mother-to-be receives invaluable instructions applicable to this or subsequent pregnancies. Following her discharge from hospital, the mother visits postnatal clinics and a visiting nurse may be asked to call on her at home. Our clinics make possible expert medical attention to less fortunate patients in their own homes.

Our Out-Patient Department is the acme of co-ordination. A patient will see a medical doctor, who may refer him to the diabetic clinic from which he may be referred to the eye clinic — and all for thirty-five cents, if the patient has it, and all for nothing if he hasn't. Do you ask me my impression of the Out-Patients'? It seems almost like a blessed work of charity, answering the question "Who is my neighbor?"

Book Reviews

Introduction to Psychobiology and Psychiatry, by Esther Loring Richards, M.D., Sc.D. 419 pages. Published by The C. V. Mosby Co., St. Louis. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 2nd Ed. 1946. Price $3.75.

Reviewed by Edith Pullan, Instructress, Provincial Mental Hospital, Essondale, B.C.

The understanding of human behavior, particularly its many abnormalities, is stressed by Dr. Richards. The psychobiological aspect is used in the approach to the subject of psychiatry. The use of this approach provides considerably more meaning to an abstract subject.

The arrangement of the contents of the book facilitates clear-cut thinking and organization of subject matter into more easily remembered groupings. This organization is advantageous in a textbook which is designed for use by students.

The text is divided into four main sections. The first is devoted to a discussion of human behavior. Here the historical background of man's study of man is sketched, with the emphasis placed on the important factors of normal human behavior and the methods of investigation of personality. The author points out their uses in the field of nursing. Part Two deals with the fundamentals of psychiatric work, the historical review, fact-gathering, and some objectives in psychiatric nursing. Part Three gives an adequate and comprehensive discourse on mental defectiveness, neuroses, and major psychoses. Part Four is in the form of an appendix, which gathers together much useful information, such as psychobiological terminology, therapeutic techniques. The grouping together of information such as this provides easy accessibility.

This book is designed for students to give them an understanding of psychiatry as well as human behavior, the knowledge of which is essential to all nurses. It is well organized and contains many short, well-synopsized case histories which adequately illustrate the various psychiatric conditions.

Nutrition and Diet Therapy, a Textbook of Dietetics, by Fairfax T. Proudfit and Corinne H. Robinson. 782 pages. Published by The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 9th Ed. 1946. Illustrated. Price $3.75.

Reviewed by Sister M. Josephine, B.H.Sc., Dietitian, St. Elizabeth's Hospital, Humboldt, Sask.

Anyone interested in nutrition and diet will find this new edition interesting and stimulating. The authors write in an easy, simple, yet interesting style. The briefness and conciseness of this new edition is to be admired. The section on diet therapy is particularly succinct and condensed. The shorter and less extensive volume has not lost any instructive value through the omission of some detail. The combining of certain chapters and the omission of charts and lengthy summaries has eliminated much repetition. This volume has compressed an amazing amount of information.

The ninth edition of this well-known and widely used text presents only a few, yet long looked for and timely changes. The change in the order of presentation of food constituents is, indeed, a most logical one. An intelligent comprehension of energy metabolism necessitates a preceding explanation of the food constituents. The arrangement is like putting the cart in front of the horse or, as the authors state in the preface of this book,—"It is like buying the combustion engine before being concerned about the fuel which the engine will burn."

The inclusion of the chapters on Safeguarding Food Supply, Feeding the Aged, and the tables giving the normal constituents of the blood and urine as well as the health

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QUEBEC PROVINCIAL DIVISION

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Maintenance:

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For further information apply to:

The Canadian Red Cross Society
Quebec Provincial Division
3416 McTavish St.
Montreal 2, Quebec

score card, should be particularly informative and useful to the public health nurse besides being an asset in the solution of incidental nutritional problems. The projects outlined at the close of each chapter present a review of the entire chapter. The extensive bibliography, the general references and the reading list are certainly designed to encourage broader reading on numerous aspects of nutrition and diet therapy. The addition of dietary case studies, the organization and the placing of the calculations and tables in the appendix, is certainly an improvement in the new edition.

Readers who are acquainted with the eighth edition will find the new one a refreshing review.

A Psychology of Growth, by Bert I. Beverly, M.D. 235 pages. Published by McGraw-Hill Book Co. Inc., 330 West 42nd St., New York City 18. 1947. Price (in U.S.A.) $2.50.

Reviewed by Katie Annesley, Instructor Royal Jubilee Hospital School of Nursing, Victoria, B.C.

This book starts by giving the foundation of mental health and then deals with the individual from infancy through preschool, school, and preadolescence, adolescence to adult life. It shows individual problems and provides discussion of adjustments which are so necessary in the process of growing up.

There is a chapter on each of the following: fears, causes of behavior problems, and juvenile delinquents. Each is very enlightening. There is a concise summary at the beginning of each chapter with a list of reference reading at the end. There also is listed a number of visual aids which would be of great value in the learning process.

It is evident that the author, who is a specialist in pediatric psychiatry, has a thorough understanding of child psychology and a sympathetic understanding of human needs at all ages. This interesting book would be helpful as a guide to instructors and students in classroom as well as on the wards, in helping them understand their own reactions as well as their patients' behavior.

Dermatology for Nurses, by K. A. Baird, M.D. 63 pages. Published by The Ryerson Press, 299 Queen St. W., Toronto 2B. 1946. Illustrated. Price $2.00.

In this small book, Dr. Baird, who is a practising dermatologist in Saint John, N.B., gives us for the first time simple answers to the question: "About what is the skin disturbed?" He indicates that most of the common skin conditions are the body's reaction against one or more of three types of offenders — living offenders, such as parasites or bacteria, physical offenders, like mechanical bruising or such a force as electricity or x-ray, and chemical substances, either externally applied or resulting in some internal reaction. He does not attempt, therefore, to distinguish in detail the hundreds of possible skin conditions to which our flesh is heir but the more ordinary conditions which the nurse may see in the course of her daily duties are discussed. It is not the nurse's function to diagnose or treat skin conditions but if she has a general unde standing of cause and effect she can assist the physician by calling his attention to some aspects of the case which may not have come under his direct observation.

One chapter is devoted to the nursing care of skin diseases and another to the steps the nurse may take as temporary measures when a doctor is not available. A few plates show the appearance of some of the skin conditions which may commonly be seen. This is a useful text for student nurses and might also be owned with advantage by public health nurses who see skin conditions, with even more frequency, in the community.

Notes on Nursing by Florence Nightingale. 82 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. Price $1.50.

Reviewed by Clara R. Aitkenhead, Nursing Arts Instructress, Homoeopathic Hospital, Montreal.

The first edition of this book appeared in print in 1859, written by Florence Nightingale, the founder of all modern nursing. Being the first book ever published on nursing it must have filled a great need and yet today, eighty-seven years later, the demand for a reproduction of it is well justified. It is very timely and might well occupy a front place in the home, in every nurse's book-case, and in every ward library. The simplicity of this book makes it easily understood by the mother or young woman in the home, on whom so often falls the care of the sick as well as the prevention of disease and the maintenance and promotion of health. More preparation of the student nurse is needed today for nursing in the home, and in this book one is impressed

by the explicit instructions and remedies pertaining to nursing care in the home, with safety and efficiency, at the same time embodying all the principles of the science of nursing as taught in schools today. The writer deals in no uncertain terms with such matters as quietness, cleanliness, and observation in addition to the specific care of the patient. The young student of today might be well advised to make a serious study of this book which should be of great assistance in her daily nursing duties to see the patient as a *person* and treat him as such. The modern conception of the care of the sick frequently confines itself to performing major nursing procedures, the administration of new drugs, etc., with little or no regard for the numerous small measures which mean so much to the patient's welfare and comfort, both mentally and physically, all of which are clearly illustrated in Miss Nightingale's "Notes on Nursing."

The Dangers of Boric Acid

From time to time newspapers report fatal accidents due to the use of boric acid. It seems timely, therefore, to print a statement on the subject. This information is drawn from an article which appeared in the *Journal of the American Medical Association*, September, 1945, entitled, "Boric Acid — A Dangerous Drug," written by Dr. Ernest H. Watson, assistant professor, pediatrics and communicable diseases, University of Michigan, Ann Arbor.

For many years, great reliance has been placed on boric acid solution as an effective antiseptic agent. It has been used for cleansing eyes, nipples, and breasts, and in the powder form has been used in open wounds. Recently much has been said and written regarding the use and the danger of this drug. Tests have shown that all forms of germs will thrive and grow in a saturated solution of boric acid. Sterile water has been found to be as effective a cleansing agent. In fact, boracic solution has been found in several instances to be the transmitting source of infection. In one hospital the boric acid used to cleanse the mothers' breasts was found to be the source of contamination in an outbreak of infantile diarrhea. Authorities agree it is wise to discontinue the use of this non-effective drug.

The potentialities of boric acid as a dangerous drug have been overlooked in the


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past. When accidentally mixed with food or drink, it has been the cause of a number of deaths. Several years ago, four infants died from boric solution which had been mistaken for sterile water. Following several such tragedies, many hospitals have removed this drug from use.

Where boric acid solution is still used in various ways, especially to cleanse the nipple prior to breast feeding, specific orders should be obtained from the doctor, clinic, or hospital for its use. If the solution is ordered for any purpose, the nurse has a responsibility to see that the mother understands its dangers, and has the container labeled and out of reach of small hands. To be even moderately effective, the solution must be prepared fresh daily with sterile water and kept in a sterile container.

Free Automobiles

Approximately 13,790 Canadian veterans of World War II who lost, or lost the use of, one or both legs have been certified as eligible to receive automobiles or other conveyances at government expense, Veterans Administration announced.

Ontario

The following are staff appointments to and resignations from the Ontario Public Health Nursing Service:

Appointments: *Irene Weirs* (Wellesley Hospital, Toronto, and University of Toronto School of Nursing) as supervisor, public health nursing, with newly-formed health unit in Counties of Leeds and Grenville; *Phyllis Thomson* (Harper Hospital, Detroit and Universities of Toronto and Western Ontario) as supervisor, public health nursing, with newly-formed Kent County health unit; *Reta Sutcliffe* (Hospital for Sick Children, Toronto, and McGill School for Graduate Nurses) as supervisor, public health nursing, with newly-formed Halton County health unit; *Margaret MacLachlan* (B.Sc.N., University of Toronto) as senior public health nurse with Simcoe County school health service after a year's leave of absence taking post-graduate study at the University of Toronto; *Mrs. Margaret Jewell* (St. Michael's Hospital, Toronto, and University

of Toronto certificate course), formerly senior public health nurse with Leaside Board of Health, to Brant County health unit; *Katharine Forbes* (Toronto Western Hospital and University of Toronto certificate course), formerly with United Counties health unit, to Ottawa Collegiate Board nursing staff; *Alice Macklin* (Victoria Hospital, London, and University of Western Ontario certificate course) to Elgin-St. Thomas health unit; *Kathleen Abbott* (Wellesley Hospital, Toronto, and University of Toronto certificate course), previously with Simcoe County school health service, to Leeds and Grenville health unit; *Fernande Lefaive* (St. Joseph's Hospital, London, and University of Western Ontario certificate course), formerly with Prescott and Russell health unit, as public health nurse with newly-formed service in the Township of Sandwich West; *Mary Pae* (Montreal General Hospital and University of Toronto certificate course) to Brant County health unit.

Resignations: *Janet Burnett* (Hamilton General Hospital and University of Toronto certificate course) as acting senior public health nurse in Simcoe County; *DorothyMcKerracher* (Royal Victoria Hospital, Montreal, and University of Western Ontario certificate course) from East York-Leaside health unit; *Evelyn Walker* (Woodstock General Hospital and University of Toronto certificate course) from Oshawa Board of Health.

News Notes

ALBERTA

Calgary General Hospital:

Miss Marion Moodie, of Montreal, first graduate of this school of nursing, was a recent visitor at the hospital and guest speaker at the June meeting of the alumnae association. Miss Moodie, who graduated in 1898, holds the distinction of being the first trained nurse in Alberta.

Going back to the days when the hospital consisted of a wooden frame building with its doors marked with bullet holes, she told of many experiences. Wearing her hospital pin, with which she was presented upon completion of her training, she told of the first simple service when she was given her diploma in the presence of several members of the hospital board, a minister, and two doctors. After doing considerable private duty in Calgary, Miss Moodie joined the staff of the hospital at Frank, Alberta, and later proceeded to the Ninette Sanato-

rium, Man. She has done considerable writing and one of her better know poetic works is the book, "Songs of the West and Other Poems."

BRITISH COLUMBIA

CHILLIWACK:

Over $140 was realized from the tea and display of arts and handicrafts recently sponsored by Chilliwack Chapter, R.N.A.B.C. The funds will be used to send food parcels to nurses in European countries and the British Isles, to help equip libraries in schools of nursing in devastated countries, and to build up the local Special Nurses' Fund. The president, Constance Bratrud, and A. MacKay, immediate past president, received the 250 guests. Members of the Chilliwack Hospital staff assisted in serving.

At the June dinner meeting of the chapter, Lyle Creelman, formerly with UNRRA, gave an interesting account of her experiences, illustrating her talk with colored slides.

ROSSLAND:

Eleven members were present at a recent meeting of Rossland Chapter, R.N.A.B.C., when Nan Kennedy presided. Dr. E. E. Topliff, the guest speaker, gave an informative address on the new drugs and also discussed the new hospitalization scheme and explained how it was effectively carried out in England. Refreshments were served by Mmes W. Roper and W. C. Stevens.

At the last meeting of the season Mrs. R. McAllister gave a report on the home nursing classes, stating that twenty-four had taken the course. Flora McLean, who attended the I.C.N. Congress, revealed that thirty-three countries were represented.

MANITOBA

St. Boniface Hospital:

A well-attended spring tea and sale of home cooking was held in April when Mrs. R. F. McWilliams, wife of the Lieut.-Governor of Manitoba, presided at the opening. The guests were received by the superior, Sr. Boisvert, the superintendent of nurses, Sr. Jarbeau, and Mary Wilson, president of the alumnae association. The proceeds went towards a $150 scholarship for a member of the 1947 graduating class for post-graduate study, and to maintain the Loan Fund, which is available to any qualified alumnae for that purpose.

Forty-nine graduates received their diplomas at the 1947 exercises, when they heard addresses by His Grace, The Archbishop of St. Boniface, and Dr. J. D. Adamson. Patricia Houston was valedictorian. Emily Zanyk won the alumnae scholarship and will take post-graduate work in public health nursing. The scholarship donated by the hospital was won by Pierrette Boucher who will take pediatric nursing. The alumnae entertained the graduating class at a dance which was much enjoyed. The patrons were Dr. and

Mrs. P. H. McNulty, Dr. and Mrs. M. Rady, Dr. and Mrs. D. S. McEwen, and Dr. and Mrs. R. Burrell. The convener for this successful event was C. Bourgeault.

Mrs. A. P. Johannson, wife of the Icelandic Consul, was guest speaker at a recent alumnae meeting when she told of her trip to Iceland and the conditions there.

SELKIRK:

Mrs. H. Henrikson, president of Selkirk Branch, M.A.R.N., was in the chair at a recent meeting when Miss Margaret E. Kerr, editor of *The Canadian Nurse*, was guest speaker. The meeting was in the home of Mrs. W. F. Langrill. Introduced by Mrs. R. B. Carpenter, Miss Kerr gave a brief outline on the founding of the *Journal* and the preparation of each issue prior to publication. Mrs. C. Kershaw thanked the speaker. Katherine Barr, convener of the *Journal* for the M.A.R.N., accompanied Miss Kerr from Winnipeg.

Winnipeg General Hospital:

The month of May saw the celebration of the 60th Anniversary of the Winnipeg General Hospital School of Nursing. Registration of former graduates, from all parts of Canada and many from the United States, took place at Marlborough Hotel with Mrs. Rex Waldie, chairman of the Anniversary Celebration Committee of the alumnae association, in charge. This was followed by a reception at the nurses' residence, given by the president and Board of Directors of the hospital. Over 420 nurses attended the dinner, held at Fort Garry Hotel, when the Mayor and Council of the City of Winnipeg honored the graduates. Dr. Charlotte Whitton spoke on "Nursing and the Challenge of Social Change," paying tribute to the fine service rendered by the hospital to the community and to nursing. The speaker was thanked by Alderman Hilda Hesson.

Mayor Garnet Coulter, in welcoming the nurses and guests, spoke of the pride Winnipeggers have in the W.G.H. and felt it fitting the city should recognize its alumnae. Miss Lynette Gunn, the alumnae's president, responding to Mayor Coulter's remarks, told of the first graduating class in 1889, and of succeeding classes who have practised their profession all over the world.

NEW BRUNSWICK

BATHURST:

Five nurses received their diplomas and pins at the graduation exercises of the Hotel-Dieu. This was the third class to be graduated. At the same time B. Chamberlain was awarded a nurses' aide certificate.

The ceremonies began with mass by Rt. Rev. Msgr. A. J. Trudel with the sermon preached by Rev. J. A. Arseneau. Dr. D. A. Thompson presided over the evening exercises when he addressed the new graduates. Dr. George Dumont, Campbellton surgeon, also spoke in French, when he rendered homage to the Religious Hospitallers of St. Joseph. Dr. L. D. Densmore, dean of active medical staff of Bathurst, extended his best

wishes to the nurses. The closing address was given by Msgr. D. Robichaud.

FREDERICTON:

Sixty-one nurses were present at the closing dinner meeting of the season held by the Fredericton Chapter, N.B.A.R.N., at D-Coy Inn. The tables were centred with bowls of tulips, the gift of Mrs. Belmore. Seated at the head table were Mrs. S. M. Rankine, immediate past president and guest of honor, Shirley Grant, president, Audrey Charters, secretary, and Edith Warman, treasurer.

During the business meeting the president welcomed a number of former members who were visiting the city, including Mrs. E. (Ross) Currie, of Montreal, Mrs. R. (Daley) Prinoe, of Toronto, and Mrs. H. (Estabrooks) Sinnett, of Newcastle. Isobel Lane gave an interesting account of the executive council meeting and Dorothy Parsons gave her impressions of the I.C.N. Congress. Mrs. C. Simms, on behalf of the members, presented Mrs. Rankine, who is leaving for Halifax, with a gift of china and a beautiful nosegay with words of appreciation for her leadership within the association.

Victoria Public Hospital:

Leta Gordon, after taking a post-graduate course at the Homoeopathic Hospital, Montreal, is now supervisor, central supply department. Other additions to the staff include Eileen Tracey, Doris Crawford, and Norma Smalley.

SAINT JOHN:

The 1947 graduating exercises of the Saint John General Hospital were honored by the presence of Lieut.-Gov. and Mrs D. L. MacLaren who extended congratulations and good wishes to the new graduates and paid tribute to the hospital and its capable staff. Also in attendance were about one hundred nurses from the other Saint John hospitals.

Dr. W. O. McDonald, in his address to the graduates, reminded them that their thoughts were more important than their actions as actions were the result of thoughts. Sonia A. Black delivered the valedictory and Rabbi A. N. Oler offered the invocatory prayer and led the graduates in repeating the Nightingale Pledge.

Prizes were awarded as follows: Ellen Cunningham, Medical Association award for highest standing in the three years' course; Sonia Black, Hospital Alumnae's award for highest standing in junior division and the Ella McGaffigan prize for general proficiency, as well as the Hospital Aid's award for junior obstetrics; Alda R. Britton, Hospital Aid's award for senior obstetrics; Jeanette MacWilliam, highest standing in surgery.

The superintendent of nurses, Margaret Murdoch, assisted J. F. H. Teed, K.C., vice-president of the board of commissioners of the hospital, in the presentation of certificates and pins.

Beatrice Selfridge presided at the dinner dance and bridge held by the alumnae association in honor of the fifty graduates of the 1947 class. Miss Selfridge gave the welcom-

ing address with Alda Britton responding. Evelyn Greene rendered two solos, while Marjorie Clark lead in a sing-song accompanied by Alberta Hanscome.

Doris Butler has joined the operating-room staff. Mrs. (Armour) Coffins has moved to Montreal while Mrs. (Black) Rankine is now in Halifax.

NOVA SCOTIA

KENTVILLE:

A recent meeting of Valley Branch, R.N.A.N.S., took the form of a picnic supper and ball game held at the Experimental Farm. Later in the evening, Margaret E. Kerr, editor of *The Canadian Nurse*, gave an interesting talk on her work. An excellent report on the R.N.A.N.S. annual meeting was presented by Mrs. C. R. Armiston.

ONTARIO

DISTRICTS 2 AND 3

OWEN SOUND:

One hundred and ten members registered for a recent meeting of Districts 2 and 3, R.N.A.O. Dr. Bruce Hallett gave the invocation and Dr. Jack Middleborough also brought greetings. Reports of the R.N.A.O. and I.C.N. Congress were given by Marion Patterson and Dora Arnold. Other interesting items included an address by Rev. Harold Vaughn, M.A., Th.D., on "Religious Therapy" and colored motion pictures depicting a trip "Through the Canadian Rockies" by Dr. A. D. Pollock. Violin and piano solos by Macey Codesky and Miss McRoberts, a student nurse, were greatly enjoyed.

A wonderful supper served under the auspices of the General and Marine Hospital Alumnae Association and a boat trip on Owen Sound Bay ended a perfect day.

KITCHENER:

Highlights of the I.C.N. Congress were given by a Scottish nurse at a recent meeting of Kitchener Chapter, Districts 2 and 3, R.N.A.O. Mary Schlichter presided. The speaker was Dorothy Patterson, superintendent of a children's hospital in Ayr, Scotland, who was introduced by Sylvia Hallman. Speaking with a rich brogue and much humor, Miss Patterson gave her impressions of America and Canada. Discussing food conditions in Scotland, she said that, at her hospital, butter and sugar were not rationed out individually. They were placed on the table and used till gone. A brief talk was also given by Olga Friesen, who recently returned after serving with UNRRA in Germany.

Stratford General Hospital:

The Stratford General Hospital Alumnae Association gave a dinner for the nineteen members of the 1947 graduating class when a prize was donated for proficiency in obstetrics.

A successful rummage sale was held and plans are being made for another one in the fall. Parcels have been sent every two months to nurses in Britain.

DISTRICT 4

NIAGARA FALLS:

The North Pavilion in Queen Victoria Park was the scene of a delightful picnic tea in honor of thirty delegates from other countries who attended the I.C.N. Congress. District 4, R.N.A.O., were responsible for arrangements and the guests were received by the chairman, Anna Oram, and Anne Blackwood and Catharine O'Farrell, presidents of the Hamilton and Niagara Peninsula Chapters. Tea followed a sight-seeing trip from Toronto to Niagara-on-the-Lake and Chippawa and later the party gathered to hear Mr. George Hamilton speak on "The Niagara Park Frontier," when colored motion pictures were also shown. Mrs. L. Lynn, Dean of Nursing, Medical College of Nurses, Shanghai, China, expressed the thanks of the visitors, most of whom then viewed the illumination of the Falls.

DISTRICT 5

At a general meeting of District 5, R.N.A.O., held in Oshawa, about 130 members were in attendance. Jessie Wallace presided. A panel of the Hamilton convention was presented by the first vice-chairman and three section conveners. Miss Wallace, as representative to the I.C.N. Congress, brought an informative report from Atlantic City.

Mr. Marshall Close, salesman for the Toronto Lithograph Company, and an associate with C. W. Wright as speech instructor, was guest speaker at the evening session. Through his topic, "To Whom Shall the Nation Look," he urged that Canadians get to know more about Canada, speak well about it, and take more interest in the science of our government. M. Bourne, superintendent of the Oshawa General Hospital, thanked the speaker.

COLLINGWOOD:

Alice Young, who has been director of nursing education at the General and Marine Hospital for the past four years, recently resigned. In her honor a reception was held by the graduate staff and student body and also attended by the board of directors and their wives. A series of presentations were made when Miss Young was the recipient of a morocco case of surgical instruments from the board, a camera from the graduate staff, a pen and pencil set from the students, and a photo album from the office staff. Speaking for the board, Mr. J. L. Smart, Miss Lund, superintendent, and Miss Robinson, on behalf of the student nurses, all expressed regret at losing the services of Miss Young.

Beatrice Welsh was also hostess at her home for Miss Young when forty guests were present. Assisting with the serving of refreshments were Mmes F. J. VanNest, J. A. Ditson, Lloyd White, Misses MacLaren and C. Shipley.

QUEBEC

QUEBEC CITY:

The Chateau Frontenac was the scene of the annual dinner given by the Jeffery Hale's Hospital Alumnae Association for the 1947 graduating class. G. Weary proposed the toast to the King while M. Dawson did the honors for the Alma Mater and M. E. Lunam for the new graduates. H. MacLean gave the response for the 1947 class and N. Humphries proposed the toast to "Absent Friends." An imaginative class prophecy was written

and presented by D. Rourke and piano selections were rendered by Mr. W. H. Ross.

Thirteen graduates received their diplomas at the exercises held the next evening. The Governors' prizes were awarded to Mrs. Travers and Jean MacTavish and D. Rourke won the Women's Auxiliary prize. The Rev. W. W. Davis, B.A., B.D., was the guest speaker for the evening and an added pleasure was the presence of Miss Gordon from England who also spoke to the graduates and guests. The Rev. H.S.B. Harper pronounced the invocation and benediction.

An enjoyable formal dance was a highlight of graduation week when graduates and guests gathered in the lounge of the nurses' residence.

Jeffery Hale's had the honor and privilege of entertaining several visiting nurses from England and the Continent who came on to Canada after attending the I.C.N. Congress.

SASKATCHEWAN

ESTEVAN:

A. Ducluzeau has returned to her position on the O. R. staff of St. Joseph's Hospital after an extended vacation in France and the French Morocco. C. Bonokoski and I. Schewgman are now on the staff of St. Joseph's Hospital and Extension respectively.

REGINA:

The newly-elected executive for Regina Chapter, S.R.N.A., consists of: Honorary president, Rev. Sr. A. Brodeur; president, Mary Brown; vice-presidents, M. Palmer and Mrs. M. Davey; secretary-treasurer and assistant, Mrs. E. Parker and E. Metz.

A successful Lilac Tea, for the nurses' registry, was held at the home of Mrs. J. Brown. Mrs. Brown and Mary Brown, the chapter president, received the eight hundred guests.

General Hospital:

Sixty-one nurses received their diplomas and pins at the 44th graduating exercises of the Regina General Hospital. Agnes Swanseid, a 1946 graduate, received a Carss Scholarship for a one-year university course.

A miscellaneous double shower was held in honor of E. Aldridge and B. Patterson who are leaving the staff to be married. Miss Aldridge has been science instructor for three years while Miss Patterson was head nurse on Ward I. E. L. Hennigar and L. E. Garland, who have completed a course in teaching and supervision at the University of Manitoba, are on the staff. Recent resignations include I. M. Ficke (Ward J) who has been called to the mission field.

Grey Nuns' Hospital:

Dr. and Mrs. Rennick and Dr. and Mrs. Ring were patrons and patronnesses for a dance given by the graduating class and an enjoyable dance was also given by the student body.

P. Graham is leaving the staff to take a teaching and supervision course at the

THE ASSOCIATION OF NURSES OF THE PROVINCE OF QUEBEC

The 1947 Fall examinations for provincial registration will cover two groups of candidates and will be held as follows:

GROUP A: Graduates qualifying for the licence to practise will write in Montreal, Quebec, and Sherbrooke on **November 17, 18, and 19, 1947.** Candidates will not be permitted to write these examinations until they have actually finished their training and hold the diploma of their School.

GROUP B: Students who will have completed their first year before **October 1, 1947,** will enter the preliminary test covering oral, practical and written, which will be held on **October 6, 7, 8, and 9, 1947.** (Time to be announced in each school.)

For application forms and all information relating to the examinations apply to the headquarters of the Association.

Applications for preliminaries must be received by **September 15, 1947,** and for finals by **October 15, 1947.**

E. FRANCES UPTON, R.N.
Secretary-Registrar
506 Medical Arts Bldg.
Montreal 25, P.Q.

University of Manitoba. P. Evans, assistant supervisor on 3C, and I. Wallwin, of the central dressing room, are leaving to be married.

SASKATOON:

Graduates from the University of Saskatchewan, with degrees in nursing, were D. James, M. Newsham, L. Selchen, N. Simpson, D. Tollerud, and W. Nicol. Miss Newsham graduated with distinction and was awarded the University Scholarship.

City Hospital:

Forty-seven nurses received their diplomas and pins at the exercises held by the Saskatoon City Hospital. The new graduates were guests of the board of governors of the hospital and the Student Nurses' Association at a formal dance.

The nurses of the hospital took part in the Tag Day sponsored by the Women's Hospital Auxiliary. Mr. George Porteous was guest speaker at a recent alumnae meeting when he gave an account of life in a Hong Kong concentration camp.

Mrs. E. Flack is now on the staff and J. Bingham, who has done post-graduate work in Rochester, N.Y., in E.E.N.T., is on the O.R. staff. H. Brayford is now studying nursing of cancer patients in New York. J. Watters and M. Cawsey, who have received scholarships, are taking pediatrics at Children's Memorial Hospital, Montreal. M. Reid is on leave of absence from Shaughnessy Hospital, Vancouver, to take tuberculosis nursing at Hamilton.

St. Paul's Hospital:

Mrs. James (Hayes) Grace, of Detroit, recently visited the hospital and school of nursing.

YORKTON:

Fourteen nurses were graduated at the Yorkton General Hospital exercises. The 1947 class were entertained at a banquet by the alumnae association and a dance was also held for them by the Yorkton Chapter.

BERMUDA

Thirty-four members attended the recent formal dinner given by the King Edward VII Memorial Hospital Alumnae Association. This was in honor of fifteen young graduates —five of last year's class and ten of the 1947 class. The guest speaker was Mrs. Albert (Barnfield) Spurling, who was matron of the hospital for three years. She was introduced by Elsie Outerbridge, the present matron, and thanked by Minna Smith. Mrs. Spurling spoke of her experiences during her term of administration and also mentioned her visit to the New York Hospital, her alma mater, for the 70th anniversary of their alumnae association.

The president, Mrs. John Nunan, awarded a prize to Rebecca Dew for gaining a place on the honor list in the Registration Examinations in Quebec.

Positions Vacant

Superintendent of Nurses. Splendid opportunity to become associated with active Anti-Tuberculosis program, treatment, and rehabilitation. Pension plan, sickness and hospitalization insurance available to staff. Apply, stating experience in administration and tuberculosis nursing, and salary expected, to Medical Supt., Freeport Sanatorium, Kitchener, Ont.

Assistant Superintendent of Nurses and **Director of Nurse Training** for 500-bed hospital in Central Canada. Initial gross salary: $2,400 per year. Apply in care of Box 6, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, P.Q.

Registered Nurses for **Pediatric-Orthopedic** Hospital. 8-hour day and 6-day week. Full maintenance or live out as desired. For further particulars apply to Supt., Shriners' Hospitals for Crippled Children, Montreal Unit, P.Q.

Public Health Nurses for City of Kingston. Salary: $1,500 to $1,800 depending on experience, with annual increments to $1,800 maximum. Superannuation. Generalized service. University city. Apply, stating qualifications and references, to Mr. C. C. Wyatt, Sec., Board of Health, Kingston, Ont.

Provincial District Nurses in Province of **Alberta.** Districts located in rural areas. Cottage, water, and fuel supplied by community. Salary: $1,920 to $2,400 per annum. Sick leave. Annual vacation provided after 1 year's service. For further information apply to Miss Jean S. Clark, Director, Division of Public Health Nursing, 218 Administration Bldg., Edmonton, Alta.

General Duty Nurses immediately. 8-hour day and 6-day week. Salary: $125 per month plus full maintenance; $30 bonus after first 6 months and $60 bonus after 12 full months' service. 3 weeks' holiday after 1 year's service. Fare from Edmonton refunded after 6 months. Modern nurses' home. Apply to Miss J. A. Ross, Matron, Municipal Hospital, Grande Prairie, Alta.

General Duty Nurses for **Operating-Room, Emergency** and **Out-Patient Dept.** Bed capacity, 575. Good salary and Cost of Living Bonus. Splendid opportunity for experience. Post-graduate and practical experience very desirable. Also **General Duty Nurses** for various depts. with opportunity for advancement. Apply, stating school, and year of graduation, age, details of experience, and date of availability for service, to Supt. of Nurses, Victoria Hospital, London, Ont.

Graduate Nurses (3) for hospital in Peace River country. Salary: $125 per month plus full maintenance. Apply to M. F. Malkinson, Sec.-Treas., Community Hospital, Fairview, Alta.

Supervisor and **General Duty Nurse** for small private hospital 60 miles from Montreal. Medicine, surgery and obstetrics. Apply, stating age, graduation, if bilingual, etc., to Dr. Kelly's Hospital, Hawkesbury, Ont.

General Duty Nurses for new 26-bed hospital. Salary: $110 per month with full maintenance. After 1 year's service, 1 month sick time with pay and free hospitalization. 2 weeks' holiday with pay. 8-hour day (7-3, 3-11, 11-7); 6-day week. No night duty except odd night of relieving. Town situated 47 miles north of Calgary on main C.P.R. line between Edmonton and Calgary with 3 trains each way every day. Good bus service. Only 80 miles from Banff National Park. 5 General Duty Nurses employed. Apply to Municipal Hospital, Didsbury, Alta.

Instructor in Nursing. State qualifications and salary expected. **General Staff Nurses.** Salary, $110 per month plus maintenance. Excellent living conditions and recreational facilities. Apply to Director of Nursing, Verdun Protestant Hospital, Verdun, Montreal 19, P.Q.

Operating-Room Charge Nurse for 80-bed hospital. Post-graduate experience preferred. Full maintenance provided; hospitalization; sick leave; holidays with pay. Apply, stating salary expected, qualifications, and date available, to Supt., Norfolk General Hospital, Simcoe, Ont.

Public Health Nurse immediately for rural work for Elgin-St. Thomas Health Unit. Salary: $1,500 a year according to experience. Car allowance, $550 a year. Assistance in car purchase can be arranged if required. Apply to Supervisor of Nurses, City Hall, St. Thomas, Ont.

Nurse for charge of **Operating-Room** in 60-bed hospital. Apply, stating salary expected, to Supt., Great War Memorial Hospital, Perth, Ont.

Registered Nurse for Community Hospital where excellent salaries are paid. Living accommodation provided. For particulars write to Dr. H. R. Clouston, Supt., County Hospital, Huntingdon, P.Q.

Graduate Nurses (2) for **General Duty** immediately. Salary: $110 per month with full maintenance. 8-hour day and 6-day week. 50 cents an hour for overtime. Apply to Little Bow Municipal Hospital No. 25, Carmangay, Alta.

Superintendent for active 20-bed hospital. Good salary and working conditions. Apply stating qualifications, to Chairman, Hospital Board, Palmerston, Ont.

Nursing Arts Instructor. Dietitian. Assistant to **Night Supervisor. General Duty Nurses.** For 250-bed General Hospital. Apply, stating qualifications, experience, and salary expected, to Supt. of Nurses, General Hospital, Brandon, Man.

Nursing Arts Instructor and **Science Instructor.** Psychiatric experience preferable but not essential. Apply, stating qualifications, experience, salary expected, and date of availability, to Supt. of Nurses, Provincial Mental Hospital, Ponoka, Alta.

Instructor of Nurses. Salary: $140 per month and full maintenance. **Dietitian.** Salary: $130 per month and full maintenance. Apply to Supt., General Hospital, Kenora, Ont.

Instructor of Nurses (qualified). Duties to commence September 1. Apply to Supt., City Hospital, Sydney, N.S.

Clinical Supervisor for 250-bed hospital. Apply, stating qualifications, experience, and salary expected, to Supt. of Nurses, McKellar Hospital, Fort William, Ont.

Obstetrical Supervisor for Royal Columbian Hospital, New Westminster, B.C. State qualifications, experience, and date of graduation in first letter. Apply to Supt.

Registered Nurses for **General Staff Nursing** in **Medical, Surgical,** and **Obstetrical** Depts. **Operating-Room Nurse** and **Assistant Night Supervisor.** For 100-bed General Hospital in Western Ontario. 8-hour day and 48-hour week. Apply, stating qualifications and salary expected, to Supt. of Nurses, General Hospital, Woodstock, Ont.

General Staff Nurses. Salary: $140 per month living out, plus laundry. Annual increment. **Operating-Room Nurses.** Post-graduate course essential. Salary: $145 living out, plus laundry. Annual increment. Accumulative sick leave. Hospitalization. Superannuation. 31 days vacation. Statutory holidays. 8-hour day and 6-day week. State in first letter date of graduation, experience, references, etc., when services would be available, and whether eligible for registration in British Columbia. Please note that investigation should be made with regard to registration in B.C. Apply to Director of Nursing, General Hospital, Vancouver, B.C.

General Staff Nurses. Initial salary: $140 per month and laundry. First increment is granted after 6 months. 8-hour day and 6-day week. 3 weeks' annual vacation. Apply to Supt. of Nurses, General Hospital, Toronto, Ont.

General Duty Nurses for 20-bed fully modern hospital. Salary: $120 per month and full maintenance. 6-day week. Apply to Supt. of Nurses, Municipal Hospital, Brooks, Alta.

Registered Nurses for **General Duty** at Haldimand War Memorial Hospital, Dunnville, Ont. Salary: $120 per month plus full maintenance. 6-day week. Long week-end once per month (3 days). 3 week's vacation with pay. Comfortable, homey residence. Pleasant surroundings. Dunnvile (pop. 4,500) is one of the beautiful progressive towns in the Niagara Peninsula. Apply to A. M. Casselman, Dunnville, Ont.

Registered Nurses (4) for **Staff Duty.** 8-hour day; 44-hour week; 5½ day week. Gross salary: $136.50 per month. For further information apply to Miss E. W. Ewart, Supt. of Nurses, Mountain Sanatorium, Hamilton, Ont.

Graduate Nurses for **General Duty** in 350-bed **Tuberculosis** Hospital. Salary: $100 per month with full maintenance. 6-day week. Good living conditions. State in first letter age, date of graduation, experience if any, and date available for duty. For further information apply to Miss M. L. Buchanan, Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, P.Q.

Registered Nurses for **General Staff** at Tranquille Sanatorium, which is situated on Kamloops Lake, near Kamloops, B.C. Gross salary for 8-hour day, 6-day week: $146.11 per month during 1st year; $156.11 per month during 2nd year; and a $5.00 per month raise in 3rd, 4th, and 5th years of service, minus $27.50 monthly for board, room and laundry. 31 days vacation per annum with pay, plus 11 days statutory holidays. 14 days sick leave each year, accumulative, with pay, plus 6 days incidental illness. Superannuation plan. Up to $50 of fare refunded. Apply to Supt. of Nurses, Tranquille, B.C.

Licensed Nurses for **General Duty** in 51-bed hospital. **Nurse** with **Operating-Room** experience. Basic salary: $114.50 per month plus full maintenance; $5.00 increase in salary after 6 months. 3 weeks' vacation each year with pay. Apply to Miss M. N. DeVere, Supt. of Nurses, Saguenay General Hospital, Arvida, P.Q.

Registered Nurses for **General Duty** at Royal Jubilee Hospital, Victoria, B.C. State in first letter year of graduation, experience, references, etc., and when available. Starting salary: $140 per month, living out. Yearly salary increases up to $160 in 4 years. Special post-graduate training—Starting salary: $150 with increases to $170 in 4 years. Laundry allowed. A few rooms available in residence. Sick leave allowance, cumulative 1½ days per month. Superannuation. 4 weeks' vacation per year with pay. Investigation should be made with regard to registration in British Columbia. Apply to Director of Nursing.

Graduate Nurses for **Operating-Room, Charge Duty,** and **General Duty. X-Ray Technician.** Apply giving experience, to Supt., Blanchard-Fraser Memorial Hospital, Kentville, N.S.

Graduate Nurse, with **Public Health** certificate, for Nursing Service in Secondary Schools. Apply, stating qualifications, experience, age, and other particulars, to Miss Mollie Towers. Sec., Board of Education, Sault Ste. Marie, Ont.

Public Health Nurses for generalized service with Peel County Health Unit. Salary: $1,800-$2,100 according to experience. Car supplied or car allowance $500-$600 per year. Unit will assist in purchase of car. Apply to Dr. D. G. H. MacDonald, Director, Court House, Brampton, Ont.

Operating-Room Nurse. Salary: $110. Full maintenance, laundry, Blue Cross Hospitalization. $60 yearly increase up to 3 years. **General Floor Duty Nurse.** Salary: $100. Same benefits. Apply, with references, to Supt., Barrie Memorial Hospital, Ormstown, P.Q.

Registered Nurse for special assignment in hospital. Opportunity for advancement. Preference given to one with post-graduate work in Tuberculosis Nursing and possessing administrative ability. Apply to Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ont.

Registered Nurses for 65-bed hospital. Salary: $140 per month with full maintenance or $150 without room. 8-hour day and 6-day week. 30 days' holiday with pay after 1 year of service. Apply to Notre Dame Hospital, North Battleford, Sask.

WANTED

for

ROSEWAY HOSPITAL, SHELBURNE, NOVA SCOTIA

General Duty Nurses for 160-bed hospital (40 beds general hospital plus 120 beds tuberculosis hospital). Salary: $1,140 per annum plus full maintenance. Pleasant living and working conditions. 6-day week; 3 weeks' holiday with full pay after a year's service.

Apply to:

N.S. CIVIL SERVICE COMMISSION,
P.O. BOX 943, HALIFAX, N.S.